

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

## CERTIFICATE OF DEATH

12452

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 days  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium  
 How long in hospital or institution? 20 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Hillandale Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 10 Rodney Road.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mrs Ida Adams

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed.  
 6.(b) Name of husband or wife Edward T. Adams  
 (deceased) 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) August 18-1895

8. AGE: Years 20 Months 4 Days 8 If less than one day..... hrs. .... min.

9. Birthplace St. Georges Island - Marys Co. Md.  
 (Town, county, and state)

10. Usual occupation Housewife.

## 11. Industry or business

FATHER 12. Name.....  
 13. Birthplace.....

MOTHER 14. Maiden name.....  
 15. Birthplace.....

16. Informant Washington San. Records

Address Burial

17. (Burial, cremation, or removal. Which?) Date thereof Dec. 29, '45  
 (month) (day) (year)

Cemetery or crematory St. Georges Island, Md.

Location Robert G. Mattingly

18. Funeral director Robert G. Mattingly

Address 131-11 St. S.E. Wash. D.C.

19. Dec 26 19 45 Registrar William D. ...

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26<sup>th</sup> 19 45 at 12<sup>35</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4 19 45 to Dec 26 19 45

and that I last saw him or her alive on December 26 19 45

Immediate cause of death Cerebral thrombosis and

Broncho-pneumonia

Due to Arteriosclerosis

Hypertension

Due to Diabetes Mellitus

Other conditions Congress rt. foot, and sacral region.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William D. ... M. D. or other

Address 805 Carroll Avenue Date signed 12-26-45

Takoma Park Md.

21 1359

RECEIVED  
DEC 28 1945  
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12453

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 mons. 1 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? 3 mons. 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ala. CountyCity or town Mobile  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1563 West Avenue  
(If rural, give LOCATION) ✓

2.(a) If veteran, name war

## 3.(a) FULL NAME

ADAMS, Orlander Chambers

## 3.(b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>W-US</u>	6.(a) Single, married, widowed, or divorced <u>married</u>
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6.(b) Name of husband or wife Mrs. Dorothy P. Adams7. Birth date of deceased (mo., day, yr.) 12 May 1899  
6.(c) If alive, give age years

8. AGE:	Years <u>46</u>	Months <u>7</u>	Days <u>6</u>	If less than one day .....hrs. ....min.
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9. Birthplace Ala  
(Town, county, and state)10. Usual occupation Steam Engineer11. Industry or business Aluminum Ore Co. Mobile, Ala12. Name Shockley A. Adams13. Birthplace Ala (dec.)14. Maiden name Coraly J. Richardson15. Birthplace Ala.16. Informant wife: Mrs. Dorothy P. AdamsAddress 1563 West Avenue, B.H., Mobile, Ala.17. cremation Date thereof 12-19-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Mobile, Ala.18. Funeral director W. W. CHAMBERSAddress 1400 Chapin Street, N. W., Wash. D.C.19. 12-18- 45 Mary Charlotte Smith

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Dec. 19 45 at 4:08 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 Sept. 19 45 to 18 Dec. 19 45 and that I last saw him alive on 18 Dec. 19 45Immediate cause of death Acute myelogenous leukemia DURATION 4 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

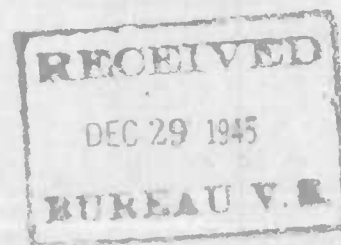
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE R. R. McCOMBS, Lt. Comdr. (MC) USNRAddress US N.H., Bethesda, Md. Date signed 12-18-45



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DEC 29 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223-

## 1. PLACE OF DEATH:

County MONTGOMERYCity or town TAKOMA PARK  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 DAYS.

Hospital, institution, or street address where death occurred:

805 MAPLE AVE.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MONTGOMERY County MONTGOMERYCity or town TAKOMA PARK  
(If outside city or town limits, write RURAL and give nearest town)Street No. 32 PEPLAR AVE.

(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

WILLIAM CLINTON ALLARD.

## 3. (b) Social Security Number

## 4. Sex

M.

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

WIDOWED.6. (b) Name of husband or wife ELIZABETH C. ALLARD.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 23, 1866.

## 8. AGE:

Years 78Months 11Days 11

If less than one day

hrs. min.

## 9. Birthplace

BALTIMORE, MD.

(Town, county, and state)

## 10. Usual occupation

CONTRACTOR AND BUILDER.

## 11. Industry or business

BUILDING TRADES.

## FATHER

## 12. Name

WILLIAM HENRY ALLARD.

## 13. Birthplace

MD.

## MOTHER

## 14. Maiden name

?

## 15. Birthplace

MD.

## 16. Informant

MRS. THELMA KENNEDY.

## Address

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof DEC. 7, 1945.  
(month) (day) (year)

## Cemetery or crematory

PROSPECT HILL CEMETERY

## Location

WASHINGTON, D. C.

## 18. Funeral director

Charles T. Carroll, M.D.

## Address

27 Carroll St., Takoma Park, D.C.

## 19.

Dec 4 45

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1945 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1945 to Dec. 4, 1945and that I last saw him alive on Dec. 3, 1945

Immediate cause of death

Cerebral Thrombosis DURATION 10 days

## Due to

Arteriosclerosis15 yrs.(cerebral)

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Charles T. Carroll M.D.

M. D. or other

Address 6801 6th St., N.W., Wash., D.C.Date signed 12/4/45

RECEIVED

DEC 7 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12455 218

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rockville Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Twenty years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Rockville Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Etta Callmuth

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Charles E Callmuth  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Oct 26 - 1862  
 8. AGE: Years 83 Months 1 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Montgomery Co Md  
(Town, county, and state)10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name Sakarah Thomas Ologitt13. Birthplace Maryland14. Maiden name Sarah E Warfield15. Birthplace Maryland16. Informant John CallmuthAddress Washington D C17. Burial Date thereof Dec 5 - 1945  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory UnionLocation Rockville Md18. Funeral director W. W. BarkerAddress Rockville Md19. 12/5/45 19. 12/5/45  
(Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 19. 45 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 12 19. 45 to Dec 3 19. 45and that I last saw him alive on Dec 2 19. 45Immediate cause of death Chronicof stomachDue to Unknown

Due to \_\_\_\_\_

Other conditions None

Major findings of operations \_\_\_\_\_

Antopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Vernon H. Ryan M. D. or otherAddress Rockville Md Date signed 12/4/45

RECEIVED AND FILED IN THE OFFICE OF THE ATTORNEY GENERAL

CERTIFICATE OF DEATH

STATE OF NEW YORK

NO. 100-100000

RECEIVED  
DEC 7 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

12456

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:  
 County..... Montg Co,  
 City or town..... clarksburg, Md,  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 78 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Md County..... Montg  
 City or town..... Clarksburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME William Olonza Anderson

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 Johns Byrne Anderson  
 8. (b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.) March 20 1867  
 6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day  
 1867 78 9 8 ..... hrs. .... min.

9. Birthplace..... Clarksburg Md,  
 (Town, county, and state)

10. Usual occupation..... Mechanic, Garage  
 " "

11. Industry or business

12. Name..... Charles T Anderson  
 13. Birthplace..... Md,

14. Maiden name..... Eliza Ann Hurley  
 15. Birthplace..... Md,

16. Informant..... Johns B Anderson  
 Address..... Clarksburg Md,

17. Burial Date thereof 12/31/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Forest Oak Cemetery  
 Location..... Gaithersburg Md,

18. Funeral director..... Ernest C Gartner  
 Address..... Gaithersburg Md

19. Dec 29 1945 Alinda J Cooke  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec 28th 45 at 12. Noo M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 Dec 25 1945 to Dec 28 1945  
 and that I last saw him alive on Dec 28 1945

Immediate cause of death..... DURATION

Pernicious Anemia

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed Dec 29 1945

RECEIVED  
JAN 2 1946  
BUREAU V  
RECEIVED  
JAN 2 1946  
BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *23a*

## CERTIFICATE OF DEATH

Reg. Dist. No. *214*

12457

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

xxxxxxx Hospital, institution, or street address where death occurred:

303 Franklin Ave, Hillandale

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 303 Franklin Ave, Hillandale  
 (If rural, give LOCATION)

2.(a) If veteran, name war No

## 3.(a) FULL NAME

GEORGE WILLIAM ANDREWS

## 3.(b) Social Security Number

none

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Gertrude Belle  
 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15th, 1866

8. AGE: Years 79 Months 7 Days 2 If less than one day hrs. min.

9. Birthplace Cleveland, Ohio  
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Architect

FATHER 12. Name William Andrews

13. Birthplace England

MOTHER 14. Maiden name Elizabeth Withercomb

15. Birthplace England

16. Informant Mrs. Theodore T. Perkins,

Address 303 Franklin Ave. Sil. Spg.

17. Burial Burial Date thereof 12/19/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or place of interment George Washington Men's

Location Riggs Rd. Pr. Georges Co. Md.

18. Funeral director Warner E. Humphrey

Address 8434 Ga. Ave. Silver Spring, Md.

19. Dec 18 1945 Josephine M Schaeffer  
 (Date rec'd by registrar) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 19 45 at 11:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 19 45 to Dec 17 19 45  
 and that I last saw him alive on Dec 16 19 45

Immediate cause of death Cerebral Hemorrhage DURATION 2 days

Due to arterio sclerosis

Due to general debility

Other conditions general debility

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Wm. A. Thomson M.D. M. D. or other

Address 112 Carroll St. W. Date signed Dec 18, 45

RECEIVED

DEC 26 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (468) K

12458

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery County  
 City or town 600 Cumberland Ave Chevy Chase, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 mo.  
 Hospital, institution, or street address where death occurred:  
600 Cumberland Ave.  
 How long in hospital or institution? Intermittently for 6 mo.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md. County Montgomery  
 City or town Chevy Chase md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 600 Cumberland Ave  
 (If rural, give LOCATION) Ch. Ch. md  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Madeleine L. Arthur

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Dr. Conrad Herbert H. Arthur

## 7. Birth date of

deceased (mo., day, yr.)

Mar. 6, 1913

## 6. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

32912

hrs.

min.

## 9. Birthplace

Virginia

(town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER

## 12. Name

Dr. J. S. Long

## 13. Birthplace

Virginia

MOTHER

## 14. Maiden name

Effie Shawalter

## 15. Birthplace

Virginia

## 16. Informant

Dr. Conrad Herbert H. Arthur

## Address

600 Cumberland Ave

## 17.

(Burial, cremation, or removal, Which?)

## Date thereof

12/21/45

## Cemetery or crematory

Baker's Cemetery

## Location

Cherdown, Md.

## 18. Funeral director

Wm Reuben Humphrey

## Address

2557 Wis. Ave. Bethesda

## 19.

(Date rec'd by registrar)

12/21 1945 M. E. Jones

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 18 December 19 45 at 4:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 December 19 45 to 18 Dec. 19 45and that I last saw her alive on 18 Dec. 19 45Immediate cause of death Carcinoma of  
the stomach with  
generalized metastasis

DURATION

Due to

Due to

Other conditions

Generalized metastasis

(Include pregnancy within 3 months of death)

Major findings of operations

1.

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. M. Davis

M. D. or other

Address

4535 Condon St. - BethesdaDate signed 18 Dec. 45

RECEIVED  
DEC 27 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12459

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Sandy Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Sandy Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Hester M. Bacon

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Samuel T. Bacon6. (c) If alive, give age 59 years

## 7. Birth date of

deceased (mo., day, yr.)

Aug. 28, 1890

## 8. AGE:

55

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

Montgomery Co. Md.

(Town, county, and state)

## 10. Usual occupation

Housekeeper

## 11. Industry or business

FATHER

## 12. Name

Thomas Fuller

## 13. Birthplace

Maryland

MOTHER

## 14. Maiden name

Mary Dorsey

## 15. Birthplace

Maryland

## 16. Informant

Samuel Bacon (husband)

## Address

Sandy Spring Rd.

## 17.

(Burial, cremation, or removal, Which?)

Date thereof

Dec. 30, 1945  
(month) (day) (year)

## Cemetery or crematory

Sandy Spring

## Location

Sandy Spring

## 18. Funeral director

Robert L. Snowden

## Address

Rockville Maryland

## 19.

(Date rec'd by registrar)

19

45

St. Andrews B. Lawler

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 19 45 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 20 19 45 to Dec. 27 19 45and that I last saw him alive on Dec. 26 19 45

Immediate cause of death

DURATION

Due to

Carcinoma Spine2 years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Calvin B. DeCompte M.D.

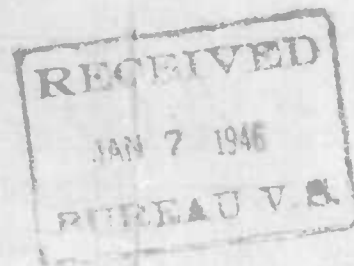
M. D. or other

Address

Wheaton Md

Date signed

12/30/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B.D.)

## CERTIFICATE OF DEATH

12460

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Sakons Park Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Wash. for Sen. & Hosp.

How long in hospital or institution?

3 days

## 3. (a) FULL NAME

Bessie, Elsie

4. Sex

Fe

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

8. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Feb. 7, 1885

8. AGE:

Years

Months

Days

If less than one day

601011

hrs.

min.

9. Birthplace

Sonya, Canada

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Dec. 21, 1945

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Dec. 19

(Date rec'd by registrar)

19. 40

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D.C. County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec 18 19 45 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that it attended deceased from

Dec 15, 1945, to Dec 18, 1945and that I last saw him alive on Dec 18, 1945

Immediate cause of death

Myocardial infarctioncongestive failure

DURATION

month

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

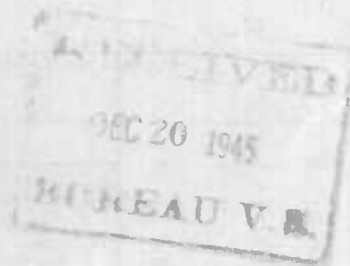
12/19/45

500 N. Howard St. NW

M. D. or other

Date signed

5th Underwood



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (b6)

## CERTIFICATE OF DEATH

Reg. Dist. No. 12461 211

### 1. PLACE OF DEATH:

County Montgomery  
 City or town Lewisdale  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 years  
 Hospital, institution, or street address where death occurred:  
at home  
 How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Lewisdale  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R. F. D. Monrovia  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war No

### 3. (a) FULL NAME

Louise R. Beall

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Windsor M. Beall

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) March 13, 1879

8. AGE: Years 66 Months 9 Days 12 If less than one day  
 .....hrs. ....min.

9. Birthplace Ellicott City, Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Charles W. Tucker

13. Birthplace Howard County, Md.

14. Maiden name Sarah M. Grimes

15. Birthplace Howard County, Md.

16. Informant Windsor M. Beall

Address Lewisdale, Md. (Monrovia)

17. Burial December 28, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethesda Methodist Church

Location Browningsville, Md.

18. Funeral director Roy. W. Barber

Address Laytonsville, Maryland.

19. Dec 27 1945 Della W. Burdette  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1945 at 9 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1935 to December 24, 1945  
 and that I last saw her alive on December 24, 1945

Immediate cause of death  
Acute cardiac failure  
(Rheumatic heart diseases  
with marked hypertrophy)

DURATION  
5 days  
60 yrs?  
5 years

Due to.....

Other conditions Pernicious Anemia  
(Diagnosed in 1941)  
 (Include pregnancy within 3 months of death)

Major findings of operations.....

None

.....Date of op. ....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury

Injured at work?

23. SIGNATURE M. McKendree Boyer  
M. McKendree Boyer, M.D.  
 Address Damascus, Maryland Date signed 12/27/45

RECEIVED BY THE BUREAU OF HEALTH

CERTIFICATE OF DEATH

STATE OF CALIFORNIA

DEPARTMENT OF HEALTH

REGISTERED MEDICAL EXAMINER

RECEIVED

JAN 3 1946

BUREAU VI

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-1

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## I. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.How long in hospital or institution? 27 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Springs  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8720 Colesville, Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

BENEDICT, Minnie M.C.

## 3.(b) Social Security Number

## 4. Sex

Female

## 5. Color or race

W-US

## 6.(a) Single, married, widowed, or divorced

Widowed.

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1877

6.(c) If alive, give age years

8. AGE: Years 68 Months 0 Days 21  
If less than one day  
.....hrs. ....min.9. Birthplace Iowa  
(Town, county, and state)10. Usual occupation House wife.

11. Industry or business

12. Name Horace L. Crookham13. Birthplace Ohio14. Maiden name Mary Ann Montgomery15. Birthplace Ohio.16. Informant Daughter: Marian M. BenedictAddress 8720 Colesville, Rd. Silver Springs, Md.17. Cremation Date thereof 31 December, 45.  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Ft. Lincoln, CemeteryLocation Washington, D.C.18. Funeral director Chamber Funeral HomeAddress 1400 Chapin St. N.W. Washington, D.C.19. 12-31 45 Mary Charlotte Smith

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 31 December, 1945. 19..... at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 Dec. 19 45, to 31 Dec. 19 45and that I last saw her alive on 31 Dec. 19 45Immediate cause of death Intestinal Obstruction  
from external causes, carcinoma  
recurrent DURATION 6-7 mons.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma recurrent  
common bile duct Date of op. 12-22-45Autopsy results Carcinomatosis abdomen

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. E. Gilje, Captain (MC) USNAddress USNH Bethesda, Md. M. D. or otherDate signed 12-31-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

418146

RECEIVED  
JAN 10 1946  
BUREAU

Reg. Dist. No. .... 216

# CERTIFICATE OF DEATH

Reg. Dist. No. .... 216

1. PLACE OF DEATH:  
County... Montgomery  
City or town... Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 29 hours  
Hospital, institution, or street address where death occurred:  
U.S. Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D. C. County .....

City or town Washington  
(if outside city or town limits, write RURAL and give nearest town)

Street No. 636 G Street, S. E.  
(if rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME  
BLACKBURN, Irving Rufus

**3. (b) Social Security Number**

4. Sex male	5. Color or race W-US	6.(a) Single, married, widowed, or divorced married	
6.(b) Name of husband or wife Mrs. Helen M. Blackburn		6.(c) If alive, give age..... years	
7. Birth date of deceased (mo., day, yr.) 15 May 1895			
8. AGE: Years 50	Months 7	Days 1	If less than one day .....hrs. .... min.

MOTHER	11. Industry or business	Navy Yard, Wash. D.C.
	12. Name	Wm. Charles Blackburn
	13. Birthplace	Va.
	14. Maiden name	Fannie Cox
	15. Birthplace	Va.

16. Informant Wife of Mrs. Helen M. Blackburn  
636 G St., S. E., Wash., D.C.  
Address

17. burial Date thereof 12-20-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Arlington, Va.  
Location

18. Funeral director W. W. Chambers B. Benson  
Address 517 11th St. S.E., Wash. D.C.  
Mary Charlotte Smith  
12-17 45 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 16 Dec. 1945 at 7:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Dec. 1945 to 16 Dec. 1945 and that I last saw him alive on 16 Dec. 1945

Immediate cause of death Arteriosclerosis  
Heart Disease

Due to Crownary Sclerosis

Due to.....

Other conditions Pulmonary Edema

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results myocardial fibrosis - Pulmonary

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... A. A. Bianco, Cmdr. (MC) USNR  
M. D. or other

Address USNH Bethesda, Md. Date signed 12-17-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 27 1945

BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12464

Reg. Diat. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Cherry Chase Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5-6 months  
 Hospital, institution, or street address where death occurred  
6900 Meadow La. Ch. Ch. Md.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.  
 City or town 6900 Meadow La. Ch. Ch. Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6900 Meadow La.  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Grace Lennox Bullock

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

B. (b) Name of husband or wife

Alexander Bullock.

7. Birth date of

deceased (mo., day, yr.)

Nov. 15, 1852

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

93116

hrs.

min.

B. Birthplace

Edenburg, Scotland

(Town, county) and state

1D. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

James Lennox

13. Birthplace

Scotland

MOTHER

14. Maiden name

Christian Fairfowl

15. Birthplace

Scotland

16. Informant

H. K. Manson

Address

6900 Meadow La. Ch. Ch.

17.

(Burial, cremation, or removal. Which?)

Date thereof

1/1/46

Cemetery or crematory

Mt. Hope Cemetery

Location

Rochester, N.Y.

18. Funeral director

Wm Reuben Humphrey

Address

Bethesda Md.

19.

(Date rec'd by registrar)

19

46Wm E Jones

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Dec 31..... 19 45, at 2:50a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 21..... 19 45, to Dec 31..... 19 45and that I last saw him alive on Dec 30..... 19 45

Immediate cause of death

DURATION

Coronary failure

Due to

Myocarditis

Due to

Atherosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. W. Bullock

M. D. or other

Address

3781 Calver St.Date signed 1/31/46

RECEIVED  
JAN 7 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46f)

## CERTIFICATE OF DEATH

12465

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 mons. 6 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? 3 mons. 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County .....City or town Dayton  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1610 Fauver Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3.(a) FULL NAME

BURKE, Harry "H", Sgt. USMC Ret. Inactive

## 3.(b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Mrs. Elise Burke

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12 Dec. 18948. AGE: Years 51 Months 0 Days 6 If less than one day ..... hrs. .... min.9. Birthplace Ky.  
(Town, county, and state)10. Usual occupation Patrolman & Instructor 1937-4511. Industry or business U.S. Marine 1916-193612. Name John Burke13. Birthplace Ky. dec.14. Maiden name Viola Murphy15. Birthplace Ky. dec.16. Informant Wife: Mrs. Elsie BurkeAddress 1610 Fauver Avenue, Dayton, Ohio17. removal Date thereof 12-19-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Spring GroveLocation Cincinnati, Ohio18. Funeral director Wm. R. PumphreyAddress 7447 Wisconsin Ave. Bethesda, Md.19. 12-19- 45 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Dec. 19 45 at 9:45P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Sept. 45 to 18 Dec. 45  
and that I last saw him alive on 18 Dec. 19 45Immediate cause of death Carcinoma of the liver with  
biliary obstruction DURATION 3 mos.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE D. B. MILLER, Lt. (MC) USNR  
M. D. or otherAddress US Naval Hosp., Bethesda, Md. Date signed 12-19-45

RECEIVED  
DEC 29 1945  
BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 100

## CERTIFICATE OF DEATH

Reg. Diat. No. 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.How long in hospital or institution? 20 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Parkthorpe  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mansfield

## 3. (b) Social Security Number

no

4. Sex

Male

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Mary E. Butler

7. Birth date of

deceased (mo., day, yr.)

Oct 9 - 1867

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

78211

hrs.

min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farmer

FATHER

12. Name

George Butler

13. Birthplace

Ind

MOTHER

14. Maiden name

Ann Barker

15. Birthplace

Ind

16. Informant

Hospital records

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Dec 24, 1945

(month) (day) (year)

Cemetery or crematory

Brooke Grove

Location

Parkthorpe

18. Funeral director

W. W. Barker

Address

Parkthorpe19. 12-21-

(Date rec'd by registrar)

19. 45Berlin

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 19. 45 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 20 19. 45 to December 20 19. 45and that I last saw him alive on December 20 19. 45

Immediate cause of death

DURATION

Due to Lobar pneumonia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work? \_\_\_\_\_

23. SIGNATURE

J. W. Daid

M. D. or other

Address Sandy Spring, MdDate signed 12/21/45

RECEIVED

JAN 7 1946

BUREAU V S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 934

## CERTIFICATE OF DEATH

Reg. Dist. No. 212

### 1. PLACE OF DEATH:

County MONTGOMERY

City or town Poolesville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montg

City or town Poolesville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Ellen Rosa Buxton

### 3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Wm L. Buxton

6. (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) June 13 - 1863

8. AGE: Years 83 Months 6 Days 3 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Frederick Co. Md  
(Town, county, and state)

10. Usual occupation Housewife

### 11. Industry or business

12. Name John Hedges

13. Birthplace England

14. Maiden name Mary Whitmore

15. Birthplace Maryland

18. Informant Miss Mary Buxton

Address Poolesville, Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 12/19/45  
(month) (day) (year)

Cemetery or crematory Mt Olivet

Location Frederick

18. Funeral director William B. Hilton

Address Barneville, Md

19. Dec 17, 45 (Date rec'd by registrar) Registrar Charles E. Egan

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1945 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1944 Jan - 1943 to Dec 16 1943

and that I last saw him alive on Dec 15 1943

Immediate cause of death myocardial infarction DURATION 2 yrs

compensatory chronic

myocarditis

Due to arteriosclerosis 15 yrs

Due to Senile decay

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Hilton D. Towne M.D.

M. D. or other

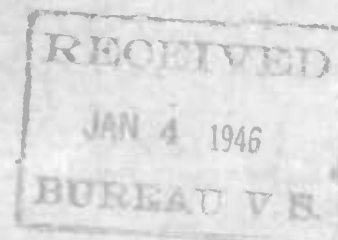
Address Danville Va Date signed Dec 17/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12467



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12468

Reg. Diat. No. 213

## 1. PLACE OF DEATH:

County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 240 N. Washington St.  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Everlyn R. Carroll

## 3. (b) Social Security Number

4. Sex Female5. Color or race col6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Forrest A. Carroll

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) February 14 - 18818. AGE: Years 64 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Rockville, Montg. Co., Md.  
(Town, county, and state)10. Usual occupation Housekeeper

## 11. Industry or business

12. Name James H. Carroll13. Birthplace Rockville, Md.14. Maiden name Margaret Norris15. Birthplace Rockville, Md.18. Informant Forrest A. Carroll (husband)Address Rockville, Maryland17. Burial Date thereof Dec. 14, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Haiti CemeteryLocation Rockville, Maryland18. Funeral director Robert L. SnowdenAddress Rockville, Maryland12/11/45- Josephine D. Hooton  
(Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1945, at 2:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. med. exam to Jan 8 1945and that I last saw him alive on Jan 8 1945

Immediate cause of death \_\_\_\_\_

## DURATION

Coronary occlusion sudden

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Frank J. Broschart M.D.Address 1211 N. Washington St. Date signed 12-8-45

RECEIVED

DEC 13 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

Reg. Dist. No. 12469 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Olney, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.How long in hospital or institution? 6 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. R#1 Laytonsville  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

Carter

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Col. Single

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 18, 1945  
 6.(c) If alive, give age years

8. AGE: Years Months Days It less than one day  
— — — 6 hrs. min.

9. Birthplace Olney, Montgomery Co., Maryland  
 (Town, county, and state)

10. Usual occupation Luxant.

11. Industry or business

12. Name Jahir Henry Carter13. Birthplace Laytonsville, Maryland14. Maiden name Marie Campbell15. Birthplace Gaithersburg, Md.16. Informant Hospital records

Address

17. Burial Date thereof 12-19-45  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory LaytonsvilleLocation Monty Co. Md.18. Funeral director Ray W. BarkerAddress Laytonsville, Md.

19. Dec. 19, 1945 Beulah B. Sewler  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1945 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18, 1945 to December 18, 1945 and that I last saw him alive on December 18, 1945

Immediate cause of death

DURATION

Prematurity

Due to

unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John B. L. M. D. or other

Address Sandy Spring, Md. Date signed 12/19/45

RECEIVED

JAN 7 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12470

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Clarksville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Elzy Carter

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Colored Single

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) August 22, 19348. AGE: Years Months Days If less than one day  
11 3 18 hrs. min.9. Birthplace Clarksville, Howard Co., Md.  
(Town, county, and state)10. Usual occupation School boy

11. Industry or business \_\_\_\_\_

FATHER 12. Name George Carter13. Birthplace Clarksville, MarylandMOTHER 14. Maiden name Julia Anderson15. Birthplace Clarksville, Maryland16. Informant Hospital record

Address \_\_\_\_\_

17. Burial Date thereof Dec. 13, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hopkins ChapelLocation Howard County, Md.18. Funeral director R. L. SnowdenAddress Rockville, Md.19. 12-13- 19 45 Bestwick Law  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 1945 at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sup. Med. Exam case 1945 to 1945  
and that I last saw him alive on 1945

Immediate cause of death

Post operative shock

DURATION

4 hoursDue to fracture of rt femur10-22-45Due to Struck by automobile10-22-45

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. 12-10-45

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-22-45Where did injury occur? Clarksville Howard Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayManner of injury struck by auto Injured at work? noFrank J. Bronhart M.D.23. SIGNATURE Sup. Med. Exam M. D. or otherAddress Clarksville, Md. Date signed 12-10-45

STANDARD FORM NO. 64

OFFICE OF THE SECRETARY OF THE ARMY

RECEIVED

JAN 2 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-22X

## CERTIFICATE OF DEATH

12471

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital, Inc.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Olney  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Thomas Carter

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ✓ years

7. Birth date of

deceased (mo., day, yr.)

August 23, 1884

8. AGE:

Years

Months

Days

If less than one day

68316

hrs.

min.

9. Birthplace

(Town, county, and state)

Maryland

10. Usual occupation

habacker

11. Industry or business

FarmFATHER  
MOTHER

12. Name

Tasker Carter

13. Birthplace

Maryland

14. Maiden name

Sarah Johnson

15. Birthplace

Maryland

16. Informant

Hospital records

Address

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Dec 19, 1945  
(month) (day) (year)

Cemetery or crematory

Mt Zion mch

Location

Montgomery Co. Md

18. Funeral director

Rev T. J. Barker

Address

Raytownville Md

19.

12-12

19

45 Centerville Laule

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1945 at 4:18 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 29 1945 to December 9 1945and that I last saw him alive on December 9 1945

Immediate cause of death

Carcinoma of the Colon

DURATION

Due to General metastasis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Same as aboveDate of op. 12/6/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

[Signature]

M. D. or other

Address Sandy Spring Md Date signed 12/10/45

RECEIVED  
- JAN 2 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 12472 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4632 4th St., N. W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

WILLIAM EDGAR CASTON

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Goldie M. Caston  
 7. Birth date of deceased (mo., day, yr.) 26 Aug. 1875 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 70 Months 3 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace S. C.  
 (Town, county, and state)  
 10. Usual occupation Retired  
 11. Industry or business Govt. Service  
 12. Name Gilliam Caston  
 13. Birthplace S. C. (dec.)  
 14. Maiden name Sue Chaplain  
 15. Birthplace S. C. (dec.)

16. Informant wife: Mrs. Goldie M. Caston  
 Address 4632 4th St., N. W., Wash., D.C.  
 17. burial Date thereof 12-20-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.  
 18. Funeral director W. W. CHAMBERS, & Benson  
 Address 1400 Chapin St., N. W., Wash., D.C.  
 19. 12-17- 45 Mary Charlotte Smith  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Dec. 45 at 9:40a M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 Dec. 45 to 16 Dec. 45  
 and that I last saw him alive on 16 Dec. 45  
 Immediate cause of death Rupture of myocardium  
 DURATION  
 Due to myocardial infarction 13 days  
 Due to \_\_\_\_\_  
 Other conditions Pulmonary Infarction 5 days  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results Rupture myocardium - Pulmonary Infarction  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE A. A. BIANCO Comdr. (MC) USNR  
 Address USNH Bethesda, Md. Date signed 12-17-45

RECEIVED  
DEC 27 1945  
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 62-8

12473

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 days  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg  
 City or town Kensington, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 100 Frederick St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Cara Allison Claggett

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 8.(b) Name of husband or wife Chas. A. Claggett  
 7. Birth date of deceased (mo., day, yr.) Nov. 23, 1866 6.(c) If alive, give age 79 years  
 8. AGE: Years 79 Months 1 Days 8 If less than one day  
hrs. min.

9. Birthplace Poolesville, Md.  
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name Louis Allison13. Birthplace Maryland14. Maiden name Clara Ellis Holland15. Birthplace Maryland16. Informant Mrs. Chas. A. ClaggettAddress Kensington, Md.17. Burial Date thereof Jan. 3, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory New St. Marys CemeteryLocation Rockville, Md.18. Funeral director Wm. Reuben HumphreyAddress 7557 Wis. Ave. Bethesda, Md.19. 1/3 19. 46 2pm E. Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1945 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Sept. 1, 1945 to Dec. 31, 1945  
 and that I last saw him alive on Dec. 31, 1945

Immediate cause of death Cardiac insufficiency & hys.  
10 yrs.

Due to Thyroxinosis  
 Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul P. Dammersfeld M.D.Address Bethesda, Md. Date signed 12/31/45

NEW YORK STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
JAN 7 1946  
BURLINGTON

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12474

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 20 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Missouri County PettisCity or town Sedalia SEDALIA  
(If outside city or town limits, write RURAL and give nearest town)Street No. 907 S. Lamine St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Miss Geraldine E. Close

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

B.(a) Single, married, widowed, or divorced

S

B.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 12, 1916

6. (c) If alive, give age years

8. AGE:

29

Years

Months

3

Days

13

If less than one day

hrs.

min.

9. Birthplace

Montana Missouri  
(Town, county, and state)

10. Usual occupation

Govt. Employee Navy Dept.

11. Industry or business

FATHER

12. Name Willis Close (Deceased)

MOTHER

13. Birthplace

Mo.

14. Maiden name

Amanda Stevens

15. Birthplace

Mo.

16. Informant

Sarah Reed

Address

17. Burial, cremation, or removal. Which?

ShipmentDate thereof 12/27/45  
(month) (day) (year)

Cemetery or crematory

Sedalia Missouri

Location

Missouri  
Wm Reuben Humphrey

18. Funeral director

Address

Bethesda, Md.

19. (Date rec'd by registrar)

12/27

19. 45

Wm E. Jones  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1945 19 25 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death Severe myocarditis DURATION

Due to

Rheumatic heart disease

Due to

Other conditions

Marginal pulmonary edema and passive congestion of all organs  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Sophie Nowakowsky M.D.  
M. D. or other

Address

Suburban Loop

Date signed

REC-511  
JAN 2 1946  
BUREAU V-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

## 1. PLACE OF DEATH:

County.....Montgomery  
 City or town.....Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MD County.....Washington D.C.  
 City or town.....Washington D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....725 Rockboro Pl. N.W.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mrs. Keoka Clouser

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married8. (b) Name of husband or wife.....William

B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Nov-15, 1900.

8. AGE:

Years

Months

Days

If less than one day

4528

hrs.

min.

9. Birthplace.....Harrisburg, Penn.  
(Town, county, and state)10. Usual occupation.....Sales lady

11. Industry or business

MOTHER FATHER

12. Name.....Gaul

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant.....Hospital Records

Address

17. (Burial, cremation, or removal. Which?)

Date thereof.....12/14/45  
(month) (day) (year)Cemetery or crematory.....Removal

Location

18. Funeral director.....The S.H. Hayes Co

Address

19. 12/14 1945  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....Dec-13, 1945 at 10:35 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4:45 AM DEC-13 1945 to 10:35 PM DEC-13 1945and that I last saw her alive on DEC-13 1945Immediate cause of death.....CONGESTIVE HEART FAILURE

DURATION

Due to.....TOXIC MYOCARDITISDue to.....PULMONARY ABSCESS & Lung DEGENERATION LEFT LOWER LOBEOther conditions.....HYPERTENSIVE HEART DISEASEDIABETES MELLITUS  
(Include pregnancy within 3 months of death)  
DERMOID CYST OVARYMajor findings of operations.....NONE

Date of op.....

Autopsy results.....AS ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Marshall Curwitt Jr. M.D.Address.....720 Dale Drive Lib. Hqs. Md.  
Date signed.....12-13-45

RECEIVED

DEC 26 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore 740

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6101 McArthur Blvd

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State DC CountyCity or town  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1619 Wisc. Ave  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Joseph Joseph Coffman

## 3. (b) Social Security Number

235-16-28254. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

59 11 hrs. min.

9. Birthplace

Grodder Mills Pa

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removed

(Burial, cremation, or removal, which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. 12/1719 45

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945 at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1945 to 19and that I last saw h. alive on 19

Immediate cause of death

DURATION

Coronary occlusiondeath  
and burial

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

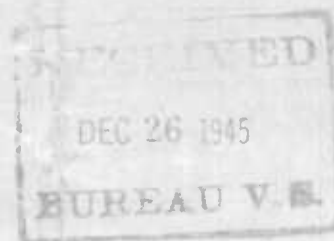
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Frank J. Bronckart M.D.  
Dep. Dir. Sec.  
Washington, D.C. Date signed 12-17-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

 12477 216  
 ★ Reg. Dist. No.

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Kensington, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? about 7 mo.  
 Hospital, institution, or street address where death occurred:  
19 Dupont St. Kensington, Md.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Kensington, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 19 Dupont St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Harvey T. Colbert

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife Deora D.  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Aug. 15, 1869  
 8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Lincoln, Va.  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Jessie Colbert

13. Birthplace Virginia

14. Maiden name Christena Vito

15. Birthplace Lincoln, Va.

16. Informant Mrs. Robert Carr

Address 19 Dupont St.

17. Burial Date thereof 12/31/45  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Goose Creek Cem.

Location Lincoln, Va.

18. Funeral director Wm. Reuben Pumphrey

Address 7557 Wis. Ave. Bethesda

19. 12/21 1945 Mr. E. Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/45 1945 3:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20, 45 to Dec. 18, 45

and that I last saw him alive on December 18, 45

Immediate cause of death Chronic

myocardial

insufficiency.

Due to Age.

Due to

Other conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wheeler O. Huff - Md.

Bethesda, Md. 12-20-45

Date signed

RECEIVED

DEC 29 1945

BUREAU V. &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

12478

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 days  
Hospital, institution or street address where death occurred:  
Suburban Hospital  
How long in hospital or institution? 20 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Bethesda Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5500 Moorland La.  
(if rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mrs. Emilie Dallett  
4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced  
Widowed  
6.(b) Name of husband or wife Charles Dallett

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-17-67

8. AGE: Years Months Days If less than one day  
78 5 22 hrs. min.

9. Birthplace Minnesota  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William McCreary

13. Birthplace Minn.

MOTHER 14. Maiden name Eliz. Oakford

15. Birthplace Phil. Pa.

16. Informant Mrs. Elizabeth D. Hoops

Address 5500 Moorland La. Bethesda

17. Shipment Date thereof 12/10/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlands Cemetery

Location Philadelphia, Pa.

18. Funeral director Wm Reuben Pumphrey

Address 7557 Wis. Ave. Bethesda, Md.

19. 12/10/45 19 45 Wm E. Jones  
(Date rec'd by registrar) Registrar

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 19 45 at 11:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death myeloid cerebral thromboses DURATION

Due to due to cardiac insufficiency

Due to

Other conditions Terminal pneumonia

(Include pregnancy within 8 months of death)

Major findings of operations Head not opened Date of op. 12/10/45

Autopsy results degeneration of myocardium, lung infarct

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sophie Nowakovsky M.D. M. D. or other

Address Date signed

RECEIVED

DEC 17 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12479 211

## 1. PLACE OF DEATH:

Country Montgomery  
 City or town Lamascus and  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Lamascus, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3.(a) FULL NAME

Adelaide Louise Day

## 3.(b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

married

## 6.(b) Name of husband or wife

Columbus W. Day

## 7. Birth date of deceased (mo., day, yr.)

June 22, 1862.

## 6.(c) If alive, give age

86 years

## 8. AGE:

Years

Months

Days

If less than one day

8368

hrs.

min.

## 9. Birthplace

Montgomery Co. Md.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Home

## MOTHER FATHER

## 12. Name

Samuel Hobbs

## 13. Birthplace

Montgomery Co. and

## 14. Maiden name

Barritte Ann B. Hobbs

## 15. Birthplace

Montgomery Co. and

## 18. Informant

Vincent Day

## Address

Lamascus Md.

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

Jan. 1, 1946  
(month) (day) (year)

## Cemetery or crematory

Lamascus Methodist

## Location

Lamascus Maryland

## 18. Funeral director

J. B. Beall, Inc.

## Address

Lamascus, Md.

## 19.

Dec 31  
(Date rec'd by registrar)45-Hella K. Burdett

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1945 at 9:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10 1945 to December 1945and that I last saw him ER alive on December 28 1945Immediate cause of death Arteriosclerotic-hypertensive  
cardio-vascular disease

## DURATION

15 yearsDue to and Cerebral thrombosis, right4 days

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

James P. Kerr M.D.

M. D. or other

Address Lamascus, Md. Date signed 12/31/45

RECEIVED

JAN 3 1945

BUREAU

# STATE OF MARYLAND—CERTIFICATE OF DEATH

12480

## 1. PLACE OF DEATH

County Montgomery  
Village or City Silver Springs  
Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Registration Dist. No. 214  
No. 722 Silver Springs Ave Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

## 2. FULL NAME

Annie M. Day If U. S. Veteran, specify WAR None  
(a) Residence: No. 722 Silver Springs Ave St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Joseph P Day</u>		
6. DATE OF BIRTH (month, day, and year) <u>April 17 1973</u>		
7. AGE <u>72</u>	Years	Months Days If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Book Binder</u>	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>U.S. Gov.</u>	
	10. Date deceased last worked at this occupation (month end year) _____	
11. Total time (years) spent in this occupation _____		

12. BIRTHPLACE (city or town) <u>Newark N.J.</u> (State or country)
13. NAME <u>William Stark</u>
14. BIRTHPLACE (city or town) <u>Pa</u> (State or country)
15. MAIDEN NAME <u>Annie Hawkins</u>
16. BIRTHPLACE (city or town) <u>Pa</u> (State or country)

17. INFORMANT (Address) <u>Ms Alice Baker</u> <u>513 Ave East District Heights</u>
18. BURIAL, CREMATION, OR REMOVAL Place <u>Cedar Hill Cemetery</u> Date <u>Dec 11, 1945</u>
19. UNDERTAKER (Address) <u>J. William Davis &amp; Son, Inc.</u> <u>300 - 4 St N.W. Washington D.C.</u>
20. FILED <u>Dec 8, 1945</u> <u>Joseph M. McKeeff</u> Registrar

## MEDICAL CERTIFICATE OF DEATH

### 21. DATE OF DEATH

December 8, 1945  
(Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from May, 1945, to December 8, 1945  
I last saw her alive on Dec. 7, 1945; death is said to have occurred on the date stated above, at 12:30 AM.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Dehydration of Cerebral Vessels  
Renal Vessels of Respiratory & Cardiac muscle

Date of onset  
1943

Other Contributory Causes of importance:

Generalized Arteriosclerosis 1943

Name of operation no Date of no

What test confirmed diagnosis? no Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of Injury \_\_\_\_\_, 19\_\_\_\_  
Where did Injury occur? \_\_\_\_\_  
(Specify city or town, county and State)  
Specify whether injury occurred In INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) W. B. Wardrop M. D.  
(Address) 943 Bonaparte St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 632

## CERTIFICATE OF DEATH

12482

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County..... Montg. Co.  
 City or town..... Rockville, Md. (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
30 yrs  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Md. County..... Montg  
 City or town..... Rockville, (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Florence Teresa DeMuth

## 3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced.....

Female White Single

B.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... 8.(c) If alive, give age..... years  
April 1st 1865

8. AGE: Years..... Months..... Days..... It less than one day.....  
1865 80 8 30 .....hrs. ....min.

9. Birthplace..... Baltimore Co., Md.  
 (Town, county, and state)  
School Teacher

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

Burial.....

Date thereof.....

Cemetery or crematory.....

Location.....

16. Funeral director.....

Address.....

19. Jan 2 19 46 Abner G. Cooke  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 31 19 45 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 43 to Dec. 31 19 45  
 and that I last saw h. er alive on Dec. 31 19 45

Immediate cause of death.....

Cerebral hemorrhage

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Esther F. Kuhn M.D.  
 Address..... Rockville, Md. Date signed 1/1/46

RECEIVED

JAN 28 1946

BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

### 1. PLACE OF DEATH:

County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Street address where death occurred:  
827 Philadelphia Ave.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 827 Philadelphia Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war No

### 3. (a) FULL NAME

MARION ASH DOAN

### 3. (b) Social Security Number

none

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband Elmer L.

8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Sept. 15th. 1887

8. AGE: Years 58 Months 3 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Penna.  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Walter P. Ash

13. Birthplace Penna.

14. Maiden name Bertha Quick

15. Birthplace Penna

16. Informant Mrs. Marion M. Mahon

Address 827 Phila. Ave. Silver Spg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/45  
(month) (day) (year)

Cemetery or crematory Fairview

Location Coatesville, Chester Co. Pa.

18. Funeral director James E. Humphrey

Address 8434 Ga. Ave. Silver Spring, Md.

19. Dec. 23 1945 Josephine M. Schaeffer  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21-45 at 4:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-17-45 to 12-21-45 and that I last saw him er. alive on 12-20-45

Immediate cause of death Cerebral thrombosis -

Due to Generalized arteriosclerosis DURATION 5 yrs.

Due to Chronic nephritis DURATION 5 yrs.

Other conditions Congestive heart failure DURATION 15 days

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma left breast

Date of op. Feb '45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. ~~VIOLENCE:~~ If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Max Shoenakulla M. D. or other \_\_\_\_\_

Address 8005 Woodbury Drive Date signed 12/22/45  
Silver Spring, Md.

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12483

RECEIVED  
DEC 28 1965  
RURAL V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
107- Park Street  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 107- Park Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

3. (a) FULL NAME

Emmett Dove

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Elizabeth D. Dove  
 6. (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) May 29-1872

8. AGE: Years 73 Months 6 Days 26 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rockville - Maryland  
 (Town, county, and state)

10. Usual occupation Florist - Retired

11. Industry or business

12. Name Thomas Randolph Dove

13. Birthplace Rockville - Maryland

14. Maiden name Louise Buchanan

15. Birthplace Floyd Hill - Virginia

16. Informant Mrs. Elizabeth A. Dove

Address 107- Park St. Rockville - Md

17. Burial Date thereof Dec 28/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rockville Union Church

Location 10- Rockville - Maryland

18. Funeral director Wm. Luther Humphrey

Address Rockville - Maryland

19. 12/26/45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1945, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from not at all to 1945  
 and that I last saw h. included in Dec. 25 1945

Immediate cause of death acute coronary occlusion  
few minutes

Due to Dr. C. E. Hawke, Rockville, Md., attended for condition

Due to Anticoagulant therapy  
2 years

Other conditions hypertension, chronic

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE W. H. Lenthorn, M.D.  
Rockville, Md. M. D. or other \_\_\_\_\_

Address Rockville, Md. Date signed 12/25/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 3 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 350

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County.....Montg. Co.  
 City or town.....Germantown (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....20 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Montgomery  
 City or town.....Rural Germantown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war.....

## 3. (a) FULL NAME

Elizabeth Elenger

## 3. (b) Social Security Number

4. Sex.....Female  
 5. Color or race.....White  
 6.(a) Single, married, widowed, or divorced.....Widow

8.(b) Name of husband or wife.....Joseph K Elenger

7. Birth date of deceased (mo., day, yr.).....Sept 1873  
 6.(c) If alive, give age.....years

8. AGE: Years.....72 Months..... Days..... If less than one day.....hrs. ....min.

9. Birthplace.....Virginia  
 (Town, county, and state)  
 10. Usual occupation.....Home work

11. Industry or business.....

12. Name.....Unknown

13. Birthplace.....Unknown

14. Maiden name.....

15. Birthplace.....

16. Informant.....Simon Bohrer

Address.....Germantown Md, R F D.

17. Burial.....Date thereof.....12/26/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Darnstown Cemetery

Location.....Darnstown. Md.

18. Funeral director.....Ernest C Gartner

Address.....Gaithersburg Md.

19. Dec 23 1945.....  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....Dec 23 1945.....at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19.....to.....19.....  
 and that I last saw him.....alive on.....19.....

Immediate cause of death.....

DURATION

Due to.....Promela - pneumonia.....4 days

Due to.....Influenza.....1 wk

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of.....

Where did injury occur?.....(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?

23. SIGNATURE.....Frank J. Borchert M.D.

M. D. or other

Address.....Gaithersburg Md. Date signed.....Dec 23 1945

RECEIVED

DEC 27 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23a

## CERTIFICATE OF DEATH

Reg. Diat. No. 12486 118

## 1. PLACE OF DEATH:

County MontgomeryCity or town Landonville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Life

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Route 19 Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1

(If rural, give LOCATION)

2(a) If veteran, name war ✓

## 3. (a) FULL NAME

Sandra J Ellis

## 3. (b) Social Security Number

mm

## 4. Sex

Female

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Warren B Ellis

## 7. Birth date of

deceased (mo., day, yr.)

May 13 - 18836. (c) If alive, give age 64 years

## 8. AGE:

Years

Months

Days

If less than one day

6274hrs.min.

## 9. Birthplace

Maryland  
(Town, county, and state)

## 10. Usual occupation

Domestic

## 11. Industry or business

Home

## FATHER

## 12. Name

Transville S Haines

## 13. Birthplace

Maryland

## MOTHER

## 14. Maiden name

Mary C Best

## 15. Birthplace

Frederick County Md

## 16. Informant

Mrs J Ernest Hawkins

## Address

Gaithersburg Md

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec 20 - 1945  
(month) (day) (year)

## Cemetery or crematory

St Elizabeth

## Location

Frederick Md

## 18. Funeral director

Gay W Barber

## Address

Landonville Md

## 19.

11/19/45

19

P Skell

Regist. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17/1945 at 1030A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/11/1945 to 12/17/1945and that I last saw him alive on 12/16/1945

## Immediate cause of death

Cerebral Hemorrhage

## DURATION

1 day

## Due to

General Arterio Sclerosis

## Due to

with Hypertension

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. —

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? —  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of Injury — Injured at work? —

## 23. SIGNATURE

JMB

M. D. or other

Address Gaithersburg Md Date signed 12/21/45

RECEIVED

DEC 26 1945

BUREAU V.B.

3

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-21

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 12487-223-

### 1. PLACE OF DEATH:

County Montgomery  
City or town Sakoma Park  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: 212 Spruce st  
Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Stay in this community (yrs., or mos., or days) \_\_\_\_\_

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County \_\_\_\_\_  
City or town Sakoma Park Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 212 Spruce st  
(If rural give LOCATION)  
2(e) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

Luther H Fowble

### 3. (b) Social Security Number

#### 4. Sex

M

#### 5. Color or race

W.

#### 6. (a) Single, married, widowed, or divorced

Married

#### B (b) Name of husband or wife

Ethel Fowble

#### 6 (c) If alive, give age \_\_\_\_\_ years

#### 7. Birth date of deceased (mo., day, yr.)

Apr 14 1872

#### 8. AGE:

Years 73

Months \_\_\_\_\_

Days \_\_\_\_\_

If less than one day

hrs. \_\_\_\_\_ min. \_\_\_\_\_

#### 9. Birthplace

Pa  
(Town, county, and state)

#### 10. Usual occupation

Retired

#### 11. Industry or business

#### 12. Name

John H Fowble

#### 13. Birthplace

Pa

#### 14. Maiden name

Elizabeth Bush

#### 15. Birthplace

Pa

#### 16. Informant

Mrs Ruth Deane

#### Address

St James Ave

#### 17.

Funeral Burial Date thereof 12-31-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

#### Cemetery or crematory

Wash D.C. 1-2-46

#### Location

#### 18. Funeral director

Huntman Funeral Home

#### Address

5732 St Anns Rd

#### 19.

Dec 21 1945  
(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

#### 20. DATE OF DEATH

12-31-45 12:00 PM

#### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 45 to December 31, 1945  
and that I last saw him alive on December 24, 1945

#### Immediate cause of death

Cardiovascular renal disease

#### DURATION

1 year

#### Due to

Primary carcinoma of esophagus;

Due to secondary carcinoma of pelvic organs

#### Other conditions

Carcinoma

(Include pregnancy within 3 months of death)

#### Major findings:

#### Of operations

#### Of autopsy

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

#### Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

#### Means of injury

#### Injured at work?

#### 23. SIGNATURE

John H Fowble

M. D. or other

#### Address

St Anne Ave

Date signed 12/31/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Coroner, Dr. James J. Boyd,  
has typed by me and will  
approve.

*[Signature]*

RECEIVED  
JAN 7 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (492) \*

## CERTIFICATE OF DEATH

12488

Reg. Diat. No. 223-

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanitarium and HospitalHow long in hospital or institution? 141 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1012 Carroll Avenue  
(If rural, give LOCATION)

2(a) If veteran, name war.....

## 3. (a) FULL NAME

Franklin Mrs. Mabel Elizabeth

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Mr. Ernest Franklin7. Birth date of deceased (mo., day, yr.) February 24, 1891 6. (c) If alive, give age..... years8. AGE: Years 54 Months 9 Days 15 It less than one day..... hrs. .... min.9. Birthplace Chicago, Illinois  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business own Home12. Name Mr. John Ehrlic Ben13. Birthplace Sweden14. Maiden name Miss Carolena Swanson15. Birthplace Sweden18. Informant Washington Sanitarium and Hospital RecordsAddress Takoma Park, Maryland17. Burial Date thereof Dec 19, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Chicago, Illinois18. Funeral director John J. TalleyAddress 257 Carroll St. N.W. Takoma Park, D.C.19. Dec 15, 1945 19 45 John J. Talley  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 19 45 9:40 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27, 1945 to Dec 15, 1945 and that I last saw him alive on Dec 15, 1945Immediate cause of death General (abdominal) Carcinomatosis DURATION 4 mos.Due to Carcinoma of both ovaries, uterus & colon 1 yr.?Due to Primary carcinoma of ovary, uterusOther conditions Ascites 1 mo.Kyrie 4 mos.

(Include pregnancy within 8 months of death)

Major findings of operations Bilateral salpingo-oophorectomyExcision Carcinos appendectomy Date of op. 8-2-45Autopsy results Refused

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE Reed H. Calver, M.D. M. D. or otherSilver Spring, Md Address..... Date signed 12-15-45

RECEIVED  
DEC 19 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12489

223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 39 hours  
 Hospital, institution, or street address where death occurred:  
Washington Sanatorium - Hospital  
 How long in hospital or institution? 39 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 109 Carroll Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Miss Elizabeth Frazier

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Jan. 3, 1888

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

57

11

24

hrs.

min.

9. Birthplace

West Virginia

(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

MOTHER FATHER

12. Name

NATHANIEL FRASIER

13. Birthplace

W. Va.

14. Maiden name

MARY ELLEN WOODS

15. Birthplace

W. Va.

16. Informant

Sanatorium Records

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Dec. 30, 1945

(month) (day) (year)

Cemetery or crematory

GEO. WASH. MEMORIAL CEM.

Location

1445 R. HUNTSVILLE M. RD. CO.

18. Funeral director

Address

19.

(Date rec'd by registrar)

1946

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

12-28

1945

at 5:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1944

19

to Dec. 28

1945

and that I last saw him alive on

Dec. 27

1945

Immediate cause of death

acute cardio vascular  
failure  
arterial hypertension  
& arteriosclerosis

DURATION

24 hrs.  
5 years

Due to

Other conditions

uterine prolapse

5 years

(Include pregnancy within 3 months of death)

Major findings of operations

uterine prolapse

Date of op.

12/27/45

Autopsy results

0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John A. Brownlee, M.D.

M. D. or other

Address

Washington San. &amp; Hosp.

Date signed

12/28/45

RECEIVED  
JAN 2 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13/2)

## CERTIFICATE OF DEATH

★ 12490 216  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Montgomery  
City or town..... Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 16 days  
Hospital, institution, or street address where death occurred:  
U. S. Naval Hospital, Bethesda, Md.  
How long in hospital or institution?..... 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... D. C. County.....  
City or town..... Washington, D. C.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2527  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

GARCIA, Elie

## 3. (b) Social Security Number

4. Sex..... M 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Mrs. May GARCIA6.(c) If alive, give age..... 48 years7. Birth date of deceased (mo., day, yr.)..... March 3, 1890

8. AGE: Years..... 55 Months..... 9 Days..... 21 If less than one day..... hrs. .... min.

9. Birthplace..... Cap Haitien, Haiti  
(Town, county, and state)10. Usual occupation..... State Department Official

## 11. Industry or business

12. Name..... Elie Garcia13. Birthplace..... Cap Haitien, Haiti14. Maiden name..... Cora Cincent15. Birthplace..... Cap Haitien, Haiti16. Informant..... Wife: May GARCIAAddress..... 3527 New Hampshire Ave., Wash., D. C.17. Removal Date thereof..... 12-24-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... Port-Au-Prince, Haiti18. Funeral director..... W.W. CHAMBERS Co., B.C.E.Address..... 1400 Chapin St., N.W., Wash., D. C.19. 12-24 19 45 May Chalth Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 24 December 19 45 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw him..... alive on..... Dec 23 19 45

Immediate cause of death.....

1) Renal failure with uremia DURATION..... 1 mo +2) Cardiac failureDue to..... nephrosclerosis

(advanced)

Due to..... hypertensive heart dis. 5 yrs +Other conditions..... hypertensive encephalopathy

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... advanced nephrosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J.E. [illegible] M. D. or otherAddress..... U.S.N.H. Bethesda Md. Date signed..... Dec 29 45

RECEIVED  
JAN 7 1946  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 726

## CERTIFICATE OF DEATH

Reg. Dist. No. 12492, 8

1. PLACE OF DEATH: Montg Co,  
County.....  
City or town..... Rockville, Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 18 yrs  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Md County..... Montg  
City or town..... Rockville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
William Henry Gartner

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife..... Lena Walker Gartner  
6. (c) If alive, give age..... 54 years  
7. Birth date of deceased (mo., day, yr.) Sept 5th 1885  
8. AGE: Years 60 Months 3 Days 15 If less than one day  
.....hrs. ....min.

9. Birthplace..... Warfordsburg, Pa.,  
(Town, county, and state)  
10. Usual occupation..... Laborer  
11. Industry or business  
12. Name..... Jacob T Gartner  
13. Birthplace Penn,  
14. Maiden name..... Flora Staley  
15. Birthplace Penn

16. Informant..... Lena W. Gartner  
Address 803 Grandine Ave, Rockville Md  
Burial 12/23/45  
17. (Burial, cremation, or removal. Which?) Date thereof.....  
(month) (day) (year)  
Cemetery or crematory..... Forest Oak Cemetery  
Gaithersburg Md  
Location Ernest C Gartner  
18. Funeral director..... Gaithersburg Md  
Address

19. Dec 22 1945 - Cloussa H. Cook  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 20 1945 at 9:10 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 4 1945 to Dec. 20 1945 and that I last saw him alive on Dec. 12 1945  
Immediate cause of death..... acute dilatation of heart  
Due to..... mitral regurgitation  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
.....Date of op. ....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE..... J. V. Hantley M.D.  
Address..... Rockville, Md Date signed 12/22/45

RECEIVED

DEC 27 1945

BUREAU V. G.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(57-2)

12492

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County MontgomeryCity or town Kennington  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

14 Conn. Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Kennington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 14 Conn. Ave  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

John A. Gassaway

## 3. (b) Social Security Number

4. Sex male5. Color or race White6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21 19438. AGE: Years 1 Months 22 Days 22 If less than one day  
hrs. min.9. Birthplace Bethesda, Montg., Md  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Norman Gassaway13. Birthplace Germanstown Md14. Maiden name Velma R. Hannaman15. Birthplace Germanstown, Md16. Informant Mrs Bessie CarterAddress 14 Conn. Ave - Kennington Md17. Buried Date thereof 12/15/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fairview Oak CemeteryLocation Fairview, Md18. Funeral director E. J. FairviewAddress Fairview, Md19. Dec 14 19 45 Charles H. Cooke  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 19 45, at 7:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Med. Exam case 19 to 19and that I last saw h. alive on 19

Immediate cause of death

Congenital heart diseaseDURATION found dead in crib

Due to

Due to

Other conditions

(Include pregnancy within 5 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brunsch M.D.  
Dep. Med. Exam M. D. or otherAddress Fairview, Md Date signed 12-13-45

RECEIVED

DEC 18 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Silvers Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Montgomery  
 City or town... Silvers Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 605 Deerfield Lane  
 (If rural, give LOCATION)  
 2(a) If veteran, name war... None

## 3. (a) FULL NAME

Agnes Genth

## 3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6. (d) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Frank E. Genth

7. Birth date of deceased (mo., day, yr.) June 19, 1867 8. (c) If alive, give age... years

8. AGE: Years 78 Months Days It less than one day

9. Birthplace... Germany  
 (Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

12. Name... J. Jurig

13. Birthplace... Germany

14. Maiden name... unk.

15. Birthplace... Germany

16. Informant... Max Francis J. Free

Address 605 Deerfield Lane

17. Cremation Date thereof Jan 2, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Free Crematory

Location... Washington, D.C.

18. Funeral director... William Lewis Co.

Address 305 - 4 St N.E. Wash. D.C.

19. Dec 31 19 45 Josephine Schaeff  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Dec 30 19 45 at 4:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 19 45 to Dec 30 19 45

and that I last saw him/her alive on Dec 29 19 45

Immediate cause of death Conjunctive  
Heart + Failure

DURATION 2 days

Due to Cardio-Vascular Heart 5 Yrs.  
Disease

Due to Asthma - Bronchial 50 Yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

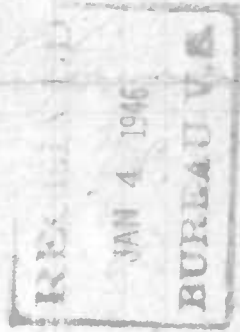
Means of injury Injured at work?

23. SIGNATURE... Harold Keger M.D.

M. D. or other

Address Washington, D.C. Date signed 12/30/46

Dr Higley  
4409- 15th St NW  
Rm 2411



100-2

CERTIFICATE OF FIDELITY  
BUILDING STATE REVENUE IN 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12494

Reg. Dist. No.

716

## 1. PLACE OF DEATH:

County.....*Montgomery*  
 City or town.....*Rockville, Md.*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....*2 weeks*  
 Hospital, institution, or street address where death occurred.....*Rockville, Md. R.F.D. #1*  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*Montg.*  
 City or town.....*Rockville, Md.*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....*R.F.D. #1*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*William Lindsay C. Giambattista*

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

*Male* *white* *Single*

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....*Sept. 18, 1945*  
 6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day  
*3* *13* ..... hrs. .... min.

9. Birthplace.....*Norfolk, Va.*  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....*Frank Daniel Giambattista*13. Birthplace.....*New Jersey*14. Maiden name.....*Olive G. Giambattista*15. Birthplace.....*Canada*16. Informant.....*Mr. Frank D. Giambattista*Address.....*Rockville, Md. R.F.D. #1*17. *Burial* Date thereof.....*1/3/46*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....*Arlington Natl. Cemetery*Location.....*Arlington, Va.*16. Funeral director.....*W. Reuben Humphrey*Address.....*7557 Wis. Ave. Beltsville, Md.*19. *1/3* *46* *Wm E Jones*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Dec 3, 1945* at *1:15 p.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Dep. med exam* 19..... to 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

*Asphyxia*Due to.....*asphyxia*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE.....*Frank J. Bronk M.D.* M. D. or otherAddress.....*Washington, Md.* Date signed.....*1-1-46*

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE STATE OF MARYLAND

DEPARTMENT OF HEALTH

RECEIVED

JAN 7 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Diat. No. 12495 216

## 1. PLACE OF DEATH:

County Montg.  
 City or town Cabin John.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 years  
 Hospital, institution, or street address where death occurred  
3rd St. Cabin John Md.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montg.  
 City or town Cabin John Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3rd St. Cabin John Md.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War #1

## 3. (a) FULL NAME

James D. Goodfellow

## 3. (b) Social Security Number

579-09-7829

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white Divorced

6.(b) Name of husband or wife Sopie

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1887

8. AGE: Years Months Days If less than one day

58 hrs. min.

9. Birthplace Del Ray Michigan10. Usual occupation Guard, Federal Govt.

## 11. Industry or business

12. Name George William Goodfellow13. Birthplace unknown14. Maiden name Mary L. Zavitz15. Birthplace unknown16. Informant Mrs. Sopie GoodfellowAddress 201-912 St. S.E. Wash. 3 D.C.17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/29/45

(month) (day) (year)

Cemetery or crematory Arlington Natl. Cem.Location Arlington Va.18. Funeral director Wm Reuben HumphreyAddress Bethesda, Md.19. 12/28 45 2pm E. J. bus

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1945, at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med. Exam 1945 to 1945and that I last saw him alive on case 1945

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brothart M.D.Address Yardley Md Date signed 12-23-45

RECEIVED  
JAN 2 1946  
BUREAU V.A.

RECEIVED  
JAN 2 1946  
BUREAU V.A.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12496

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 days  
Hospital, institution, or street address where death occurred:  
8600 Old Georgetown Rd. Bethesda  
How long in hospital or institution? 6 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montg.  
City or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6209 Melville Place  
(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

Mrs. Frances Ruth Gould

### 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
6. (b) Name of husband or wife Samuel P. Gould (Deceased)  
6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of 1-21-79  
deceased (mo., day, yr.)

8. AGE:	Years	Months	Days	If less than one day
<u>66</u>	<u>11</u>	<u>24</u>	_____ hrs.	_____ min.

8. Birthplace Rochester, N. York  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Jeremiah Gould

13. Birthplace Co. Cork, Ireland

14. Maiden name Helen Irwin

15. Birthplace Rochester, N. York

16. Informant Dr. Frederick Thomas Gould

Address 6209 Melville Pl. Ch. Ch. Md.

17. Cremation Date thereof 12/29/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Maryland - Pumphrey

18. Funeral director Wm. Reuben Pumphrey

Address 7557 Wis. Ave. Bethesda, Md.

19. 12/28 19 45  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 19 45 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/21 19 45 to 12/27 19 45

and that I last saw her alive on 12/27 19 45

Immediate cause of death myocardial infarction

uncomplicated

Due to myocardial infarction

Due to coronary occlusion -

genit. arteriosclerosis

Other conditions angine pectoris

extremity

(Include pregnancy within 3 months of death)

Major findings of operations left infarction of left

Severe coronary artery sclerosis with

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Sophie Novakovsky M.D.

Address pathologist at Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JAN 2 1946

BUREAU V.A.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 128

## CERTIFICATE OF DEATH

12497

216

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 month  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 1 month

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D. C. County .....  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4317 Kansas Avenue, N. W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

GRUND, August Christopher, Pl/Sgt. USMC

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Mrs. August C. Grund  
7. Birth date of deceased (mo., day, yr.) 19 Feb. 1916 8.(c) If alive, give age..... years  
8. AGE: Years 29 Months 9 Days 16 If less than one day.....hrs. ....min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH 5 Dec. 19 45 at 8:10 P.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 Nov. 19 45 to 5 Dec. 19 45  
and that I last saw him alive on 5 Dec. 19 45

Immediate cause of death Acute Hemorrhagic Pancreatitis  
DURATION weeks

Due to .....  
Due to .....  
Other conditions Pancreatitis 10 days  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
Date of op.....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE F. S. Ashburn M. D. or other  
Address US NH Bethesda, Md. Date signed 12-6-45

9. Birthplace Maryland (Town, county, and state)  
10. Usual occupation Marine Corps  
11. Industry or business  
12. Name Charles L. Grund  
13. Birthplace Md. (dec)  
14. Maiden name Margaret Knight  
15. Birthplace Md. (dec)  
16. Informant wife: Mrs. August C. Grund  
Address 4317 Kansas Avenue, N. W., Wash., D.C.  
17. burial Date thereof 12-10-45  
(Burial, cremation, or removal. Which) (month) (day) (year)  
Cemetery or crematory Arlington National  
Location Arlington, Va.  
18. Funeral director Geo. W. Wise J.C.F.  
Address 2900 M St. N. W., Wash., D.C.  
19. 12-6- 45 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEC 17 1945  
BUREAU V.S.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County Montgomery

Village or City Olney (Montg. Co. Gen'l Hospital)

Registration Dist. No. 217

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## 2. FULL NAME Katherine Olds Hamilton

(a) Residence: No. Forest Glen, Md. St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

If nonresident give city or town and State

### PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5a. If married, widowed, or divorced

HUSBAND or  
(or) WIFE of Stanislaus Murray

6. DATE OF BIRTH (month, day, and year) Jan. 8th. 1861

7. AGE Years 84 Months 11 Days 6 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Nevada  
(State or country)

13. NAME Mark L. Olds

14. BIRTHPLACE (city or town) Ohio  
(State or country)

15. MAIDEN NAME Katherine Sargeant

16. BIRTHPLACE (city or town) New York  
(State or country)

17. INFORMANT Mrs. Berry E. Clark  
(Address) Silver Spring, Md.

18. BURIAL, CREMATION, OR REBURY  
Place Washington, D. C. Date 12/17/45

19. UNDERTAKER Warner E. Pamphrey - dec.  
(Address) Silver Spring, Md.

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_  
Registrar Gentle & Sons

### MEDICAL CERTIFICATE OF DEATH

#### 21. DATE OF DEATH

December 14, 1945  
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1945, to Dec. 14, 1945

I last saw him alive on Dec. 14, 1945; death is said to have occurred on the date stated above, at 9:40 P. M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Sobar pneumonia  
acute dilatation of heart Date of onset Dec. 3

Other Contributory Causes of Importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) G. J. Hartley

(Address) Rockville, Md.

M. D.

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dec. 20. 1945

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

Reg. Dist. No. 1249

## 1. PLACE OF DEATH:

County MontgomeryCity or town Fairland Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Private Home, Fairland Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Fairland  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

MARTHA - ELIZABETH - HARDING

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Sam. Harding7. Birth date of deceased (mo., day, yr.) Nov. 14 - 1859 B. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 86 Months 1 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name Martin Poole

13. Birthplace

14. Maiden name Brown15. Birthplace Maryland16. Informant Mrs. Lottie WrightAddress Fairland, Md.17. Burial Burial Date thereof Dec. 20, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Union CemeteryLocation Baltimore, Md.18. Funeral director F. Arthur MartenAddress 254 Carroll St. Tak Park19. Dec. 18 45 Josephine M. Charles  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1945 4:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 10 1943 to 12 18 1945and that I last saw him alive on 12 47 1945Immediate cause of death PneumoniaPneumonia

DURATION

Due to Secondary Ascaris

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. Pyburn

M. D. or other

Address Fairland Md.Date signed 12-18-45

RECEIVED

DEC 26 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 526

## CERTIFICATE OF DEATH

Reg. Dist. No. 13

12500

## 1. PLACE OF DEATH:

County MontgomeryCity or town Falls Road, Rockville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Falls Road  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Charles Edward Hebron

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Feb - 6 - 1907

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

38103

hrs.

min.

9. Birthplace

Potomac, Montg. Md.  
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

William H. Hebron

13. Birthplace

Blauvelt, Md.

MOTHER

14. Maiden name

Bessie Johnson

15. Birthplace

Sugarland, Md.

16. Informant

Wm. Johnson (Father)

Address

Rockville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Dec 13, 45

(month) (day) (year)

Cemetery or crematory

Church Cemetery

Location

Sugarland, Md.

18. Funeral director

R. L. Snowden

Address

Rockville, Md.

19. 12/13/45

(Date recd by registrar)

Josephine D. Patton

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1945 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept - 1, 1945 to Dec - 9, 1945and that I last saw him alive on December - 8 - 1945

Immediate cause of death

Acute endocarditis

DURATION

2-3 days

Due to

inflammatory rheumatism3 mos.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William C. Miller M.D.

M. D. or other

Address

Gruthersburg, Md.Date signed 12/11/45

RECEIVED

DEC 19 1945

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 yrs  
 Hospital, institution, or street address where death occurred:  
402 Carroll Ave  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 402 Carroll Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Bernie Heumann

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Rose Heumann  
 7. Birth date of deceased (mo., day, yr.) Jan 27 1881  
 8. AGE: Years 64 Months 11 Days 24 If less than one day - hrs. - min.

9. Birthplace Germany  
 (Town, county, and state)  
 10. Usual occupation storekeeper  
 11. Industry or business merchant  
 12. Name Abraham Heumann  
 13. Birthplace Germany  
 14. Maiden name Berta Lachman  
 15. Birthplace Germany

16. Informant Rose Heumann  
 Address 402 Carroll Ave - Takoma Park  
 17. Burial Date thereof Dec 23, 1945  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory Wash. Hebrew Cemetery  
 Location Wash D.C.  
 18. Funeral director D. Nanzansky & Son  
 Address 3501 - 14th St NW Wash DC  
 19. Dec. 21 45  
 (Date rec'd by registrar) Registrar J. M. Nantz

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1945 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. med. exam 1945 to 1945  
 and that I last saw him alive on 1945

Immediate cause of death Coronary occlusion  
 Due to arteriosclerosis  
 Due to -  
 Other conditions -  
 (Include pregnancy within 3 months of death)

Major findings of operations -  
 Date of op. -

Autopsy results -  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide - Date of -  
 Where did injury occur? - (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) -  
 Means of injury - Injured at work? -  
 23. SIGNATURE Frank J. Broschard M.D.  
Sept. med. exam  
Washington Ind M. D. or other -  
 Address - Date signed 12-21-45

RECEIVED  
DEC 26 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

Reg. Dist. No. 12502 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Cherry Chase, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.  
 Hospital, institution, or street address where death occurred:  
5 East Pike, Ch. Ch. Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.  
 City or town Cherry Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5 East Pike St. Ch. Ch.  
 (If rural, give LOCATION) Md.

2.(a) If veteran, name war

## 3. (a) FULL NAME

Miss Jennie Hodges

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

Sept. 17, 1862

## 8. AGE:

Years

Months

Days

If less than one day

83

.....hrs. ....min.

## 9. Birthplace

Egta, Meinn  
(Town, county and state)

## 10. Usual occupation

Retired School Teacher

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Emerson Hodges

## 13. Birthplace

New York State

## 14. Maiden name

Amelia Buck

## 15. Birthplace

Pa.

## 16. Informant

Miss Helen E. Hodges

## Address

5 East Pike St. Ch. Ch.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Dec. 10, 1945  
(month) (day) (year)

## Cemetery or crematory

Rock Creek Cem.

## Location

Wash. D. C.

## 18. Funeral director

Wm. Reuben Humphrey

## Address

7557 Wis. Ave. Bethesda

## 19.

12/8

19

45Wm E. Jones, Md.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1945 at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Med. Exam. case  
and that I last saw h..... alive on ..... 19.....

## Immediate cause of death

Coronary occlusion

## DURATION

1 hr.

Due to.....

Due to.....

Other conditions

Astoria, sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work?

23. SIGNATURE

Dr. J. Broschart M.D.  
Dep. Med. Exam.

M. D. or other

Address Yonkers, N.Y. Date signed 12-8-45

RECEIVED

DEC 17 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 576 X

## CERTIFICATE OF DEATH

Reg. Dist. No. 12503 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Norbeck  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.City or town Norbeck  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Thomas Holland Jr.

## 3. (b) Social Security Number

4. Sex Male5. Color or race Colored6.(a) Single, married, widowed, or divorced Married8.(b) Name of husband or wife Emelyn W. Holland6.(c) If alive, give age 58 years7. Birth date of deceased (mo., day, yr.) December 8, 18718. AGE: Years 74 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Ellen Mount, Md.  
(Town, county, and state)10. Usual occupation Farmer

## 11. Industry or business

12. Name Thomas Holland Sr.13. Birthplace Norfolk, Va.14. Maiden name Cecelia Holland15. Birthplace Virginia16. Informant Emelyn Holland (wife)Address Norbeck, Maryland17. Burial Date thereof Dec 9, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Pleasant CemeteryLocation Norbeck, Maryland18. Funeral director R. L. SnowdenAddress Rockville, Maryland19. Dec 7 19 45 Seated Lawler  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 19 45 at 8:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to Dec. 6 19 45and that I last saw him alive on Dec. 6 19 45Immediate cause of death Carcinoma of prostateDURATION 3 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operation Prostatic cystotomy for prostate obstructionDate of op. July 1945Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. R. Lathrop M.D.Address Rockville, Md. Date signed 12/6/45

RECEIVED

JAN 7 1946

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### I. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County

City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 27 A M Street, S W., Wash., D.C.  
(If rural, give LOCATION)

2.(a) if veteran, name war

### 3. (a) FULL NAME

JACKSON, John Westerly, VBP

### 3. (b) Social Security Number

4. Sex

Male

5. Color or race

N-US

6.(a) Single, married, widowed, or divorced

widower

6.(b) Name of husband or wife Emily JACKSON

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 13, 1891

8. AGE:

Years

Months

Days

if less than one day

54

2

25

hrs. min.

9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name John JACKSON

13. Birthplace Richmond, Va. (dec)

14. Maiden name unknown

15. Birthplace Va. (dec)

16. Informant Sister-in-law: Mrs. Marie Gray

Address 27 A M Street, S. W., Wash., D.C.

17. burial Date thereof 12-12-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lincoln Memorial

Location Wash. D.C.

18. Funeral Director John T. RHINES, & Co.

Address 3rd and Eye Street, S.W., Wash., D.C.

19. 12-8 45 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Dec. 19 45 at 11:50 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 Dec. 19 45 to 8 Dec. 19 45

and that I last saw h. im alive on 8 Dec. 19 45

Immediate cause of death Hypertensive Heart Disease

DURATION

18 mos.

Due to Hypertension

Due to

Other conditions General Arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. A. BIANCO, Comdr. (MC) USNR

M. D. or other

Address USNH Bethesda, Md. Date signed 12-8-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
DEC 26 1945  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-29 X

## CERTIFICATE OF DEATH

Reg. Dist. No. 12505 214

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Shiloh Springs  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yrs. 6 mos.  
 Hospital, institution, or street address where death occurred:  
1909 Locust Grove Rd.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MD County Montgomery  
 City or town Shiloh Springs  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1909 Locust Grove Road  
 (If rural, give LOCATION)

2.(a) If veteran, name War

## 3. (a) FULL NAME

Calvin Ambrose Jenkins

## 3. (b) Social Security Number

None

4. Sex Mr. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Annie Cross Jenkins  
 7. Birth date of deceased (mo., day, yr.) August 10, 1880 6.(c) If alive, give age 59 years  
 8. AGE: Years 65 Months 4 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace MD.  
 (Town, county, and state)

10. Usual occupation Mechanic

11. Industry or business

Retired12. Name Jacob Jenkins13. Birthplace MD.14. Maiden name Annie Barnes15. Birthplace MD.16. Informant Mrs. Annie JenkinsAddress 1909 Locust Grove Rd. Shiloh Springs

17. Burial Date thereof Dec. 15, 1945  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Freedom CemeteryLocation in Shilohville, Md.18. Funeral director C. Harry ReedAddress Shilohville, Md.

19. Dec. 13 19 45 Josephine W. Schaeffer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 19 45 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12 19 43 to Dec 12 19 45  
 and that I last saw him alive on Nov. 30 19 45

Immediate cause of death

Carcinoma of Cecum and lower Sigmoid

DURATION

2 1/2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Cecum and Sigmoid Flexure of Colon Date of op. November, 1944

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Schaeffer M.D.

Address 925 Shiloh Ave. Shiloh Springs, Md. Date signed Dec. 13, 1945  
 M. D. or other

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

STATE OF MASSACHUSETTS

DEPARTMENT OF HEALTH

RECEIVED

RECEIVED  
DEC 26 1945



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

12506

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
 County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 hours  
 Hospital, institution, or street address where death occurred:  
U S Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1630 D St., N. E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

3.(a) FULL NAME

JENSEN, Sofus Christan Louis

3.(b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Mrs. Lillian Jensen  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) 16 July 1893  
 8. AGE: Years 52 Months 5 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Denmark  
 (Town, county, and state)  
 10. Usual occupation Navigators  
 11. Industry or business Ocean Cargo Ships (Coastal)  
 12. Name Christan Jensen  
 13. Birthplace Denmark (dec)  
 14. Maiden name Larson  
 15. Birthplace Denmark (dec)

16. Informant wife: Mrs. Lillian Jensen  
 Address 1630 D Street, N. E., Wash., D.C.  
 17. burial Date thereof 12- -45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National  
 Location Arlington, Va. W J S.  
 18. Funeral director Lee Funeral Home  
 Address 14th & Mass., Ave., N.E., Wash. D.C.  
Mary Charlotte Smith  
 19. 12-29-45 Mary Charlotte Smith  
 (Date rec'd by registrar) (Date) (Month) (Year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Dec. 45 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Dec. 45 to 28 Dec. 45 and that I last saw him alive on 28 Dec. 45

Immediate cause of death Coronary Heart Disease DURATION 1 year

Due to arteriosclerosis

Due to \_\_\_\_\_

Other conditions Pneumonia 2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results Coronary Ht. Disease; Bronchopneumonia Date of op. \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. A. BIANCO Comdr. (MC) USNR  
 Address USNH Bethesda, Md. Date signed 12-28-45

1/3/46

RECEIVED

JAN 10 1946

BUREAU V S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

## CERTIFICATE OF DEATH

12507

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Suburban Hospital  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Rockville, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 308 Falls Rd.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mrs. Annie Laura Karn

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Frank H.

7. Birth date of deceased (mo., day, yr.) March 8, 1873 6.(c) If alive, give age..... years

8. AGE: Years 72 Months Days If less than one day..... hrs. .... min.

9. Birthplace Hyattstown, Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Philip Duntrow

13. Birthplace Maryland

14. Maiden name Achsaht Duntrow

15. Birthplace Hyattstown, Md.

16. Informant Mrs. Frank Karn

Address Rockville, Maryland

17. Burial Date thereof 12/27/45  
(Burial, cremation, or removal; White?) (month) (day) (year)

Cemetery or crematory Rockville Union Cem.

Location Rockville, Maryland

18. Funeral director Wm. Reuben Thompson

Address 7557 Wis. Ave. Bethesda, Md.

19. 12/27 1945 Wm E Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Dec 1945, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1945 to 24 Dec 1945 and that I last saw him alive on 24 Dec 1945

Immediate cause of death Degenerative type of anemia

Due to Unknown

Due to

Other conditions Chronic anemia

(Include pregnancy within 3 months of death)

Major findings of operations

Antemortem results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W S Murphy Md. M. D. or other

Address Rockville Md. Date signed 26 Dec 45

MARGIN RESERVED FOR BINDING

VS A15-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAINTAINING STATE DEPARTMENT IN RECORD

CERTIFICATE OF DEATH

IN THE STATE OF NEW YORK

MICHAEL J. BURKE

RECORDED

JAN 2 1946

BUREAU V

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12508 223

### 1. PLACE OF DEATH:

County Montg  
City or town Lakewood Park  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: 1009 Flower Ave  
Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Stay in this community (yrs., or mos., or days) 6 yrs

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Montg  
City or town Lakewood Park Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 1009 Flower Ave  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

Matthias M Kieger

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife Eleana M

7. Birth date of deceased (mo., day, yr.) Apr 28 1898

8. AGE: Years 47 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Mich  
(Town, county, and state)

10. Usual occupation Partner-Owner

11. Industry or business Mid Cycle Co.

12. Name Matthias M Kieger

13. Birthplace Germany

14. Maiden name Kathryn

15. Birthplace Mich

16. Informant Mrs Eleana Kieger

Address 1009 Flower Ave

17. Burial Date thereof 12-13-45

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt Olivet Cem.

Location Wash DC

18. Funeral director Wentworth Funeral Home

Address 5732 Ga Ave

19. Dec 13 19 45 John Dell

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

2D. DATE OF DEATH December 13 19 45, at 4:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-27 19 39, to 12-13 19 45, and that I last saw him alive on 12-13 19 45.

Immediate cause of death Coronary Occlusion DURATION 4 1/2 hrs.  
Due to Coronary Sclerosis 6 yrs.  
Due to Generalized Arteriosclerosis 8 yrs.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. H. Kieger M.D. M. D. or other \_\_\_\_\_

Address 8005 Woodbury Drive Date signed 12/13/45

MARGIN RESERVED FOR BINDING

(I)

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STANDARD INFORMATION SYSTEM

STANDARD INFORMATION SYSTEM

STANDARD INFORMATION SYSTEM

STANDARD INFORMATION SYSTEM

RECEIVED  
DEC 15 1945  
BUREAU V.6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

125-9

Reg. Diat. No. 714

## 1. PLACE OF DEATH:

County MontgomeryCity or town RURAL Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years

XXXXX street address where death occurred:

Arcola Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town RURAL Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. Arcola Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

HARRY JOSEPH KING

## 3. (b) Social Security Number

-----

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife XXXXX Alice Mary Dennis7. Birth date of deceased (mo., day, yr.) Jan. 15, 1878

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day  
67 10 24 hrs. min.8. Birthplace Baltimore County, Md.  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Share Crops12. Name Alfred King13. Birthplace Unknown14. Maiden name Louise Dennington King15. Birthplace Unknown16. Informant Mrs. Alice Mary KingAddress R. #1, Silver Spring, Md.17. Burial Date thereof Dec. 11, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory xxxxx Fort Lincoln CemeteryLocation Bladensburg Road, Md.18. Funeral director Warner E. PumphreyAddress Silver Spring, Md.19. Dec 10 19 45 Joseph M. Schaaf  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 19 45, at 7:30 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Ref. med. Exam case 19 45 to 19 45  
and that I last saw him alive on 19 45

Immediate cause of death

Coronary occlusion

DURATION

acute suddenly

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brochart M.D. M. D. or otherAddress Yantherburg Md Date signed 12-9-45

RECEIVED

DEC 26 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12510 218

## 1. PLACE OF DEATH:

County MontgomeryCity or town Clarksburg (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Sandy M. Krig

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

12/9/1933

8. AGE:

Years

Months

Days

If less than one day

126hrs.min.

9. Birthplace

MD

(Town, county, and state)

10. Usual occupation

School

11. Industry or business

FATHER

12. Name

Henry E. Krig

13. Birthplace

MD

MOTHER

14. Maiden name

Edna M. Rowood

15. Birthplace

MD

16. Informant

Edna M. Krig

Address

Clarksburg MD

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Dec 18, 1945

Cemetery or crematory

Clarksburg MD

Location

Montgomery

18. Funeral director

Ray W. Barker

Address

1218/90

19. (Date rec'd by registrar)

12/18/45

19.

R. A. Biele

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MD

County

Montgomery

City or town

Clarksburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

✓

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15/45 1945 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

12/15/45 10:00 AMand that I last saw him alive on 12/15/45

Immediate cause of death

Fracture 3rd Cr -  
neck vertebra, some spine  
skid -

Due to

Intra cranial Hem-  
orrhage

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accident

Date of

12/15/45

Where did injury occur?

Clarksburg Mont.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (whore?)

Public Highway

Means of Injury

Hit by Automobile

Injured at work?

23. SIGNATURE

Forail app. Pathologist

M. D. or other

Address

Sandy Spring MDDate signed 12/15/45

RECEIVED  
DEC 26 1945  
BUREAU V S.

VS A15

I

MARGIN RESERVED FOR BINDING

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH

12511

Reg. Dist. No. 214

### 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7709 Takoma Ave

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7709 Takoma Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war.

No

### 3. (a) FULL NAME

PERSIE JULIAN LATHAM

### 3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

B.(b) Name of ~~husband~~ wife Edith L. S.

7. Birth date of deceased (mo., day, yr.) Nov. 20th. 1868 6.(c) If alive, give age..... years

8. AGE: Years 77 Months 1 Days 2 If less than one day..... hrs. .... min.

9. Birthplace Washington, D. C.  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Abner O. Latham  
13. Birthplace Grafton, W. Va.

14. Maiden name Felicia Sturgis  
15. Birthplace unknown

18. Informant Mr. Julian S. Latham

Address 7709 Takoma Ave. Takoma Park, Md.

17. Burial Date thereof 12/24/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rock Creek

Location Washington, D. C.

18. Funeral director Warner E. Pumphrey  
Address 8434 Ga. Ave. Silver Spring, Md.

19. Dec 23 19 45 Josephine M. Schaeffe  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 19 45 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 19 19 45 to Dec. 22 19 45  
and that I last saw him alive on Dec. 22 19 45

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 days

Due to arteriosclerosis

Due to

Other conditions old age

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wm. A. Shannon M.D.

M. D. or other

Address 113 Carroll St. N.W. Wash. D.C. Date signed Dec 22/45

RECEIVED  
DEC 28 1945  
BY MAIL

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Bethesda, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Waverley Sanitarium  
 How long in hospital or institution? 2 months, - 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... N.J. County...  
 City or town... MONTCLAIR  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 37- NO MOUNTAIN AVE  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

FRANCES McMULLEN LEE

## 3. (b) Social Security Number

Has none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife

Charles T. Lee

7. Birth date of deceased (mo., day, yr.)

Sept. 24 1865

8. AGE: Years Months Days If less than one day

80 yrs. 0 mos. 0 days 0 hrs. 0 min.

9. Birthplace

Schenectady N.Y.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or removal. Which?

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

December 18 1945 at 9:52 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 1st 1945 to Dec. 18 - 1945

and that I last saw her alive on December 18 - 1945

Immediate cause of death

Cerebral hemorrhage

Due to

Arterio-sclerosis - 8 years

Due to

Age

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

RECEIVED

DEC 26 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 98-1

## CERTIFICATE OF DEATH

12513

Reg. Dist. No. 223-

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? 24 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 9412 Warren Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Lunow Mrs. Gertrude

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Robert Lunow

7. Birth date of deceased (mo., day, yr.)

June 6 18946. (c) If alive, give age 53 years

8. AGE:

Years

Months

Days

If less than one day

51630

hrs.

min.

9. Birthplace

Saxony Germany  
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

FATHER

12. Name

Friedrich OTTO Schinke

13. Birthplace

Leipzig Germany

MOTHER

14. Maiden name

Anna Pauline Kreische

15. Birthplace

Eben Leiz Germany

16. Informant

Sister Elisabeth Schinke

Address

244 East 86th St. New York City

17. CREMATION

(Burial, cremation, or removal. Which?)

Date thereof 12-28-45

(month) (day) (year)

Cemetery or crematory

FORT LINCOLN

Location

BLADENSBURG RD PRINCE GEORGES CO.

18. Funeral director

Adams & Pumphrey

Address

8434 GAFF - SILVER SPRING - MD

19.

(Date rec'd by registrar)

19

45122845122845122845

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1945 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. - July 1945 to 12/26/1945

and that I last saw him

Immediate cause of death

Apoptotic heart disease  
obstructive failure

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Holahan M.D.  
302 W. Howard St. N.W. M.D. or other  
Date signed 12/26/45

RECEIVED  
DEC 28 1945  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12514

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Olney, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.  
19 days

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Sandy Spring  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Miss Mary Magruder

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FemalewhiteSingle

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

August 22, 1865

8. AGE:

Years

Months

Days

If less than one day

80329

hrs.

min.

9. Birthplace

Brookeville, Montgomery Co., Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

FATHER

12. Name

William E. Magruder

13. Birthplace

Brookeville, Maryland

14. Maiden name

Mary Hammond

15. Birthplace

Howard Co., Maryland

16. Informant

Hospital record

Address \_\_\_\_\_

17.

Cremation

(Burial, cremation, or removal. Which?)

Date thereof

Dec 22, 1945  
(month) (day) (year)

Cemetery or crematory

J. W. Lee Sons

Location

Washington D.C.

18. Funeral director

Robt W. Bator

Address

Rockville, Md

19.

12-21-  
(Date rec'd by registrar)

19.

H. S. Andrews, Lawler  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1943 to December 21 1945and that I last saw her alive on December 21 1945

Immediate cause of death

DURATION

Carcinoma of bladder3 mts.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Charles E. Imbleson

M. D. or other \_\_\_\_\_

Address Sandy Spring, Md Date signed 12/21/45

RECEIVED

JAN 7 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

## CERTIFICATE OF DEATH

Reg. Dist. No. 12515 263 216

## 1. PLACE OF DEATH

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Nannie L. Marshall4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced divorced6. (b) Name of husband or wife John Y. Marshall6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) July 9 18788. AGE: Years 67 Months 4 Days 28 If less than one day

hrs. min.

9. Birthplace Stafford co. Va  
(Town, county, and state)10. Usual occupation housework

11. Industry or business

12. Name Chas Pearson13. Birthplace Va14. Maternal name Mary F Pearson15. Birthplace Va16. Informant Charles V. BartelmeAddress 6801 Exfair Rd. Bethesda Md17. (Burial, cremation, or removal, Which?) BuriedDate thereof 12-8-45  
(month) (day) (year)Cemetery or crematory Washington Dc

Location

18. Funeral director W.W. Chambers CoAddress 307 N M St NW19. 12-8-45 NE Jones  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6801 Exfair Rd

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1945 at 8:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Inf med Exam 19 19and that I last saw h. alive on 19 19

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brochart M.D.Inf med Exam M. D. or otherAddress Washington Dc Date signed 12-7-45

RECEIVED

DEC 26 1945

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-5)

## CERTIFICATE OF DEATH

Reg. Diat. No. 12516 3/2

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Sugarland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Sugarland  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary L. Mason

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Charles Mason7. Birth date of deceased (mo., day, yr.) May 15, 19116. (c) If alive, give age 37 years8. AGE: Years 34 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation House keeper

11. Industry or business \_\_\_\_\_

12. Name Phillip S. Johnson13. Birthplace md14. Maiden name Nettie Branison15. Birthplace md.18. Informant Charles Mason (Husband)Address Sugarland, md.17. Burial, cremation, or removal. Which? Burial Date thereof Dec 23, 1945  
(month) (day) (year)Cemetery or crematory SugarlandLocation Sugarland, Maryland18. Funeral director P. H. SnowdenAddress Rockville, Md.19. Dec. 22, 45 (Date rec'd by registrar) Registrar Charles A. Egan

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 - 1945 at 12 noon21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/18 1945, to 12/19 1945 and that I last saw her alive on 12/18 1945Immediate cause of death Pulmonary Tuberculosis

DURATION

4 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

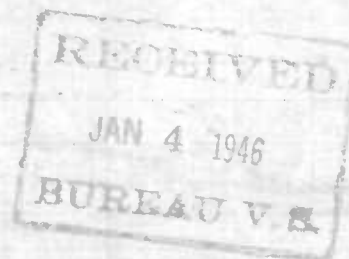
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE B. D. White, M.D. M. D. or other \_\_\_\_\_Address Rockville, Md. Date signed 12/20/45

RECEIVED

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 3 hours, 40 minutes

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. #2  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

HARRY LEE MILLER

### 3. (b) Social Security Number

214-05-9531

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1889

8. AGE: Years Months Days If less than one day  
56 0 19 hrs. min.

9. Birthplace White Oak, Md.  
(Town, county, and state)

10. Usual occupation... Handyman

11. Industry or business

12. Name... Lewis Miller

13. Birthplace Md.

14. Maiden name... Annie Lindsey

15. Birthplace Md.

16. Informant... Mrs. Mildred V. Amos

Address White Oak, Md.

17. Burial Date thereof... Dec. 10, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Colesville Cemetery

Location Colesville, Md.

18. Funeral director... Warner E. Pumphrey

Address Silver Spring, Maryland

19. 12-8-45 19... V.E. Joder  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH... Dec. 6th 1945 at 7:40p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-28-37 19... to 12-6 1945  
and that I last saw him alive on 12-6-45 7:45pm. 19...

Immediate cause of death

Massive subarachnoid hemorrhage

DURATION

3 hrs

Due to Hypertensive Heart Disease.

12 yrs

Due to Old Left Hemiplegia

1 yr 2 mos

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leanneth Daugherty M.D.  
M. D. certifier

Address 8252 Sa Ave Date signed 12-6-45

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 26 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

## CERTIFICATE OF DEATH

Reg. Dist. No. 12518 223-

## 1. PLACE OF DEATH:

County MontgomeryCity or town Potomac Park - Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

210 Flower Ave.How long in hospital or institution?                     

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Potomac Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 210 Flower Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war                     

## 3. (a) FULL NAME

Josephine J Miller

## 3. (b) Social Security Number

4. Sex Female5. Color or race White6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife                     6.(c) If alive, give age                      years7. Birth date of deceased (mo., day, yr.) Feb. 16 - 18918. AGE: Years 74 Months 10 Days 5 If less than one day                      hrs.                      min.9. Birthplace White Lake Ohio  
(Town, county, and state)10. Usual occupation At Home11. Industry or business                     12. Name Erskine Allen13. Birthplace Holland, Co Ohio14. Maiden name Margaret Alice Goursen15. Birthplace Ohio16. Informant Mrs. J. Herman SimbleAddress 210 Flower Ave. Potomac Park17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec 24 1945  
(month) (day) (year)Cemetery or crematory                     Location Medisonville Fayette Co Ohio18. Funeral director                     Address 254 Laurel Pl Potomac Park19. 12/21 19 45  
(Date rec'd by registrar)Registrar                     

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 19 45 at                      M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from last year 1945 to 12/21/45 and that I last saw him alive on                      19                     Immediate cause of death Myocardial heartfailure with arteriosclerosisDue to Coronary occlusionOld hemiplegiaDue to                     Other conditions                     

(Include pregnancy within 3 months of death)

Major findings of operations                     Date of op.                     Autopsy results                     

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:                     Accident, suicide, or homicide                      Date of                     

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)                     Means of injury                      Injured at work?                     23. SIGNATURE Chas. H. Holston MDAddress 500 Underwood NW M. D. or other                     Date signed 12/21/45

RECEIVED  
DEC 28 1945  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

<b>1. PLACE OF DEATH:</b> County <u>Montgomery</u> City or town <u>Faithsburg</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Life time in County</u> Hospital, institution, or street address where death occurred: <u>206- Frederick Road</u> How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Montgomery</u> City or town <u>Faithsburg</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>206- Frederick Road</u> (If rural, give LOCATION) 2. (a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>Martha S. Nicholson</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Female</u>		<b>5. Color of race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widowed</u>			
<b>6. (b) Name of husband or wife</b> <u>Vernon H. Nicholson</u>				<b>6. (c) If alive, give age</b> _____ years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>August 8-1862</u>							
<b>8. AGE:</b> Years <u>83</u>		Months <u>3</u>		Days <u>23</u>		If less than one day _____ hrs. _____ min.	
<b>8. Birthplace</b> <u>Sedan Grove - Maryland</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>House wife</u>							
<b>11. Industry or business</b> <u>Own house</u>							
<b>MOTHER</b>	<b>12. Name</b> <u>Richard E. Furclum</u>						
	<b>13. Birthplace</b> <u>Montg Co - Maryland</u>						
	<b>14. Maiden name</b> <u>Acornick Brown</u>						
<b>FATHER</b>	<b>15. Birthplace</b> <u>Montg. Co - Maryland</u>						
	<b>16. Informant</b> <u>Vernon Nicholson (son)</u>						
	<b>Address</b> <u>206- Frederick Rd - Faithsburg</u>						
<b>17. Burial</b> (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>Dec. 4/45</u> (month) (day) (year)							
<b>Cemetery or crematory</b> <u>Bahm Cemetery</u>							
<b>Location</b> <u>Sedan Grove &amp; Montg. Co. Md</u>							
<b>18. Funeral director</b> <u>Wm Ruben Humphrey</u>							
<b>Address</b> <u>Rockville - Maryland</u>							
<b>19. Rec'd by registrar</b> <u>Dec 4 1945</u> <u>Alvinda S. Smith</u> Registrar							
<b>MEDICAL CERTIFICATION</b>							
<b>20. DATE OF DEATH</b> <u>Dec 12</u> 19 <u>45</u> at <u>3:02 P.M.</u>							
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Jan</u> 19 <u>45</u> <u>Dec 12</u> 19 <u>45</u> and that I last saw him/her alive on <u>Dec 12</u> 19 <u>45</u> Immediate cause of death <u>Acute myocardial</u> <u>and cerebral thrombosis</u> <u>and cerebral thrombosis</u> <u>Superficial thrombosis</u> Due to _____ Due to <u>enlargement of thyroid</u> <u>gland - myxomatous degeneration</u> Other condition <u>degeneration</u> (Include pregnancy within 3 months of death)							
<b>DURATION</b> <u>5 days</u> <u>3 mos</u> <u>25 yrs</u>							
<b>Major findings of operations</b> _____ Date of op. _____							
<b>Autopsy results</b> _____							
<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>							
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____							
<b>23. SIGNATURE</b> <u>Upton S. Haines M.D.</u> <u>Dawsonville Md. P.O. Boyd</u> Address _____ Date signed <u>12/1/45</u>							

RECEIVED

DEC 8 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County MontgomeryCity or town Washington Grove  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Washington Grove  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

ANNE PACE

## 3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Feb 19 18816. (c) If alive, give age 64 years8. AGE: Years 64 Months 10 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Boysd, Md.  
(Town, county, and state)10. Usual occupation Auditor Bankkeeper

11. Industry or business

12. Name William R. Pace13. Birthplace Virginia14. Maiden name Arietta J. Childs15. Birthplace Maryland16. Informant William R. PaceAddress Washington Grove, Md17. Burial Date thereof Jan. 1, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Forest Oak CemeteryLocation Smithersburg, Md.18. Funeral director Wm. Gordon HumphreyAddress Landover, Md.19. Dec 31 1945 Charles G. Cooke  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 30 December 19 45, at 11:00 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 December 19 45 to 30 Dec. 19 45  
and that I last saw her alive on 30 Dec. 19 45

Immediate cause of death \_\_\_\_\_

Fatemia, chronic

DURATION

+ dayDue to Ulcers, trophic, Gangrene4 mos.Due to Arteriosclerosis, general20 yrs.Other conditions Arthritis deformans14 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE G. D. Dwyer, M.D.

M. D. or other

Address Dunkerville, Md. Date signed 31 Dec 45

UNITED STATES DEPARTMENT OF JUSTICE

WYANT 10-20-1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 223-12520

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park - Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 days  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hospital  
 How long in hospital or institution? 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia  
 County D.C.  
 City or town Washington D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1552 - 44th St. N.W.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war ✓

## 3. (a) FULL NAME

(western)

Ethel Crews Page

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Singly, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Arthur S. Page  
 6. (c) If alive, give age 56 years  
 7. Birth date of deceased (mo., day, yr.) March 26 1890  
 8. AGE: Years 55 Months 8 Days 12 If less than one day hrs. min.

9. Birthplace Danville - Virginia  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business —

FATHER 12. Name Josiah Crews  
 13. Birthplace Virginia  
 MOTHER 14. Maiden name Sarah Russell  
 15. Birthplace Virginia

16. Informant Sanitarium records and husband  
 Address —

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof 10 Dec 45  
 (month) (day) (year)  
 Cemetery or crematory Belair Hill  
 Location Hugh Maryland  
Lee Funeral Home

18. Funeral director Lee Funeral Home  
 Address 300 - 4th St. N.E.

19. Dec 5 45 (Date rec'd by registrar) Registrar John R. Bell

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8-45 at 8:20 M.  
 21. I CERTIFY that death occurred on the data above stated; that I attended deceased from January 1936 to 12-8-1945  
 and that I last saw her alive on 12-7-1945

Immediate cause of death Uremia  
 DURATION 48 hours  
 Due to Cerebral Hemorrhage 7 days  
 Due to Generalized Arteriosclerosis and Malignant Hypertension 10 years  
 Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —  
 Date of op. —

Autopsy results —  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:  
 Accident, suicide, or homicide — Date of —  
 Where did injury occur? — (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) —  
 Means of injury — Injured at work? —

23. SIGNATURE McShenahill M. D. or other —  
 Address 8005 Woodbury Drive Date signed 12/8/45  
Belair Springs, Md.

RECEIVED

DEC 12 1945

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Kensington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred:

180 Prospect St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 18 Prospect Street

(If rural, give LOCATION)

2.(a) If veteran, name war No

## 3.(a) FULL NAME

Mrs. Ma Belle Palmer

## 3.(b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

Whit

## 6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Frank Palmer7. Birth date of deceased (mo., day, yr.) August 13, 1869

6.(c) If alive, give age ..... years

8. AGE: Years Months Days It less than one day  
76 76 3 27 .....hrs. ....min.9. Birthplace New York State  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name Nathaniel Palmer13. Birthplace New York State14. Maiden name Margaret De Nise15. Birthplace New York State16. Informant Mrs. Margaret Bean (Daughter)Address Kensington, Maryland17. Shipment Date thereof 12/30/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fairhaven CaliforniaLocation California18. Funeral director Wm. E. JonesAddress Bethesda Md.19. 12/12/45 1945 Wm E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 1945, at 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 20 1945, to Dec 10 1945and that I last saw him/her alive on Dec 7 1945Immediate cause of death Carcinoma of Breast withmetastasis

## DURATION

4 years

Due to .....

Due to .....

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

.....Date of op. ....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Richard V. Matthews M.D.Address 4707 Conn Ave N.W. Date signed 12/10/45

RECEIVED

DEC 27 1945

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 242

## CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:  
County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? one month & six days  
Hospital, institution, or street address where death occurred:  
U.S. Naval Hospital, Bethesda, Md.  
How long in hospital or institution? one month & six days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State N.Y. County \_\_\_\_\_  
City or town Long Island  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3534 84th St., Jackson Hgts.  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

3.(a) FULL NAME PHILLIPS, Byron (n) 3.(b) Social Security Number \_\_\_\_\_

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Mrs. Hazel N. Phillips  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) 8 October 1893  
8. AGE: Years 52 Months 2 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Texas  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business Navy

FATHER 12. Name unknown  
13. Birthplace unknown  
MOTHER 14. Maiden name unknown  
15. Birthplace unknown

16. Informant wife: Mrs. Hazel N. Phillips

Address 3534 84th St., Jackson Hgts. Long Is. N.Y.

17. burial Date thereof 12-29-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National  
Location Arlington, Va.

18. Funeral director Geo. W. Wise, 9 C3  
Address 2900 M st N. W., Wash., D.C.

19. 12-27- 45 Mary Charlotte Smith  
(Date rec'd by registrar) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Dec. 19 45, at 10:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 Nov. 19 45 to 26 Dec. 19 45  
and that I last saw him alive on 26 Dec. 19 45

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Due to Syphilitic Chondritis of the coccyx 2 wks.

Due to Hemolytic Staphylococcus

Other conditions Furuncle - skin 6 wks.  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE LL Barkus M. D. or other \_\_\_\_\_  
Address US N.H., Bethesda, Md. Date signed 12-27-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 7 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(12)

## CERTIFICATE OF DEATH

Reg. Dist. No. 223-

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Washington Sen. & HospitalHow long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war. \_\_\_\_\_

## 3. (a) FULL NAME

Mr. James J. Phillips

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife. \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) No record

8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 78 Months 6 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace St. Clair, Penna.  
(Town, county, and state)10. Usual occupation Retired

## 11. Industry or business

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

16. Informant Records of Wash. Sen. & Hosp.  
Address Takoma Park, Md.17. Buried Date thereof Dec 11, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Geo. Wash. Memorial CemeteryLocation Edge Rd. Hyattsville, Md.18. Funeral director Arthur J. PhillipsAddress 551 Carroll St., Takoma Park, D.C.19. Dec 9 19 45  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 19 45 at 7:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 19 45 to Dec 8 19 45  
and that I last saw him alive on Dec 8 19 45

Immediate cause of death

Ascites due to  
chronic congestion

## DURATION

Due to Bronchial Asthma

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE Henry J. Brown M.D.

M. D. or other

Address Takoma Park, Md.Date signed 12/8/45

RECEIVED  
DEC 12 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yearsHospital, institution, or street address where death occurred:  
22 East Bradley Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6315 Woodside Place  
(If rural, give LOCATION)2(a) If veteran, name war No

## 3. (a) FULL NAME

MRS. SIDNEY HOWARD PHILLIPS

## 3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>divorced</u>

6. (b) Name of husband or wife Hugh Jackson Phillips7. Birth date of deceased (mo., day, yr.) December 3, 1869

8. AGE:	Years	Months	Days	If less than one day
<u>76</u>	<u>76</u>	<u>0</u>	<u>10</u>	<u>hrs. min.</u>

9. Birthplace Salisbury, Maryland  
(Town, county, and state)10. Usual occupation Housewife  
None

11. Industry or business

12. Name Albert J. Benjamin13. Birthplace Leslie, Maryland14. Maiden name Aline Naisby15. Birthplace Philadelphia, Pa.16. Informant Mr. Howard W. Phillips (son)Address Chevy Chase, Maryland17. Burial Date thereof December 15/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Manokin Church CemeteryLocation Wicomico Co., Princes Anne, Md.18. Funeral director Wm. Ruden HumphreyAddress Bethesda, Maryland19. 12/15 1945 Wm E Jones

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1945, at 9 AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 10 1944, to Dec. 13 1945and that I last saw him alive on Dec. 13 1945Immediate cause of death Heart Block dueto Arteriosclerotic HeartDiseases.DUE TO Senile Arteriosclerosis DURATION 40 yearsChronic Pyelitis 10 yearsDUE TO Hypertensive Heart DiseaseOther conditions Chronic Pyelitis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alma Jane Speer M.D.

3225 Garfield St. N.W., M. D. or other

Address Washington, D.C. Date signed 12/13/45

RECEIVED

DEC 26 1945

BUREAU V S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

### 1. PLACE OF DEATH:

County Montgomery County  
City or town Rural - Mt Airy  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Damascus  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Maria Louisa Pickett

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife David Murray Pickett

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1885 8.(c) If alive, give age 57 years

8. AGE: Years 88 Months 3 Days 27 if less than one day hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Christian Snyder

13. Birthplace Maryland

14. Maiden name Mary Miller

15. Birthplace Maryland

16. Informant Mrs Barry Watkins

Address Mt. Airy and

17. Burial Date thereof Dec 30, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pine Grove Cem

Location Mount Airy and

18. Funeral director J. B. Beall Inc.

Address Damascus, Md

19. Dec 30 19 45 Della V. Burdett  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1945, at 4:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 2, 1945 to Dec 29, 1945

and that I last saw him alive on Dec 28, 1945

Immediate cause of death Ch. Uremia DURATION 3 mo

Due to Ch. Interstitial Nephritis 2 yrs

Due to

Other conditions Ch. Myocarditis 2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE Stanley Grabill M. D. or other

Address Mt Airy, Md Date signed 12/29/45

MARGIN RESERVED FOR BINDING

VS 4151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 3 1946  
BUREAU VA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4514 Drumond Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

PINNEY, Frank Lucius, Captain USN Ret.Inct.

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

W-US

## 6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Mrs. Mary Brogden Pinney7. Birth date of  
deceased (mo., day, yr.)2 Dec. 1874

6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

7103

.....hrs. ....min.

## 9. Birthplace

Conn.

(Town, county, and state)

## 10. Usual occupation

Navy (retired)

## 11. Industry or business

FATHER

## 12. Name

Lucius Pinney

## 13. Birthplace

Conn.

MOTHER

## 14. Maiden name

Mary Holbrook

## 15. Birthplace

N.Y.16. Informant wife: Mrs. Mary B. PinneyAddress 4514 Drumond Avenue, Ch.Ch., Md.17. burial  
(Burial, cremation, or removal. Which?)Date thereof 12-5-45  
(month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.

## 18. Funeral director

Reuben PUMPHREYAddress 7557 Wisconsin Avenue Bethesda, Md.19. 12-5-  
(Date rec'd by registrar)19 45Mary Charlotte Smith

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5 Dec. 19 45 at 6:20A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 PM 12/4 19 45 to 6:20AM 12/5 19 45 and that I last saw him alive on 12/5 19 45

Immediate cause of death

Cerebral Hemorrhage

DURATION

10 hrs.

Due to

Hypertension5 yrs +

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

23. SIGNATURE

Robert M. Smith H. C. SmithM. D. or other MDAddress Washington Med Center Bethesda Date signed 12/5/45

RECEIVED

DEC 17 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

## 1. PLACE OF DEATH:

County MontgomeryCity or town Damascus, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Damascus, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William E Potts

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Col

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Mary E Potts

7. Birth date of

deceased (mo., day, yr.)

Dec 2 18676.(c) If alive, give age 77 years

8. AGE:

Years

Months

Days

If less than one day

78023

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Retired

FATHER

12. Name

William Potts

13. Birthplace

Md.

MOTHER

14. Maiden name

Margaret Hammond

15. Birthplace

Md.

16. Informant

Mary E. Potts

Address

Damascus, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof Dec 25, 1945

(month) (day) (year)

Cemetery or crematory

Friend Shippe, Md.

Location

Clarksburg, Md.

18. Funeral director

Rev. J. Barber

Address

Clarksburg, Md.

19.

(Date rec'd by registrar)

19 45Della V Burdett

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 19 45 at 3:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 11 19 43 to December 25 19 45and that I last saw him alive on December 30 19 45Immediate cause of death Cerebral hemorrhage, left

DURATION

1 week

Due to

Arteriosclerotic cardiovasculardisease15 years

Due to

Senility15 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James P. Kerr, M.D.

M. D. or other

Address

Damascus, Md.Date signed Dec 27, 1945

RECEIVED  
JAN 3 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (158)

## CERTIFICATE OF DEATH

12529

Reg. Dist. No. 223-

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanatorium + Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District CountyCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3618 Jocelyn St. N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Unnamed baby boy Prewitt

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

12-7-45

6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

7 hrs.18 min.

## 9. Birthplace

Takoma Park, Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

FATHER  
MOTHER12. Name Mr. Jovett Bernard Prewitt13. Birthplace Limeaus Co., Missouri14. Maiden name Violet Pauline Joyner15. Birthplace Iredell Co., N.C.16. Informant Santerum Records

Address

17. BurialDate thereof 12-10-45  
(month) (day) (year)

(Burial, cremation, or removal, which)

Cemetery or crematory

George Washington Memorial Cemetery

Location

Ridge Road, Prince Geo City, Md.

## 18. Funeral director

257 Carroll St. N.W. Tak Park, DC19. Dec 9 1945  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8 1945 at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8:15 3pm 12-7-1945 to 4:25am 12-8-1945and that I last saw him alive on 12-7-1945Immediate cause of death Parturition  
at 29 wks.

## DURATION

Due to cause unknown

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Emma Hughes M.D.

M. D. or other

Address Takoma Park, Md. Date signed 12-8-45

RECEIVED

DEC 12 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30d

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 mo. 28 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 mo. 28 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State N.Y. County \_\_\_\_\_  
 City or town New York City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 154-66 Riverside Dr.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

RANDALL, Albert Borland, R.Adm.USNR Ret.Inact.

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Dorothy C. Randall  
 7. Birth date of deceased (mo., day, yr.) 11 Sept. 1879 8. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 66 Months 2 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Long Is., N. Y.  
 (Town, county, and state)  
 10. Usual occupation Navy (retired)  
 11. Industry or business \_\_\_\_\_  
 12. Name William C. Randall  
 13. Birthplace N.Y.  
 14. Maiden name Dorothy C. Boyer  
 15. Birthplace Missouri

16. Informant wife: Mrs. Dorothy C. Randall  
 Address 154-66 Riverside Dr., N. Y.  
 17. burial Date thereof 12-4-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National Cemetery  
 Location Arlington, Va.

18. Funeral director W. W. Chambers W. W. Chambers  
 Address 1400 Chapin St., N. W., Wash., D. C.  
 19. 12-3- 45 Mary Charlotte Smith  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Dec. 19 45 at 8:19 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 Oct. 19 45 to 1 Dec. 19 45  
 and that I last saw him alive on 1 Dec. 19 45

Immediate cause of death Rupture of aortic aneurysm into pericardium

## DURATION

Due to Smudged aortic aneurysm

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. J. Straub J. J. Straub, Lt. Comdr. (MC) USNR  
 M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 12-3-45

RECEIVED

DEC 17 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2 K

12531

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

Suburban Hospital13 days 3 1/2 hr.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Riverdale  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5810 Cleveland ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Bertram Reeder

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Rosa

7. Birth date of deceased (mo., day, yr.)

June 22, 1877

6.(c) If alive, give age years

8. AGE:

Years 68 Months 5 Days 27 If less than one day hrs. min.

9. Birthplace

England  
(Town, county, and state)

10. Usual occupation

Retired Auditor & Chief Acct.

11. Industry or business

Interstate Commerce Com.

MOTHER FATHER

12. Name

George Reeder

13. Birthplace

England

14. Maiden name

Emma Tiffin

15. Birthplace

England

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

12/19/45  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19 45Wm E. Jones  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-19, 19 45, at 12:32 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw alive on 19 45, at 12:32 P.M.

Immediate cause of death

Paralytic ileus

DURATION

PeritonitisfollowingDue to Cancer of  
the sigmoid.Other conditions Pulmonary edema

(Include pregnancy within 3 months of death)

Major findings of operations

Cancer of the  
intestine Date of op. Dec. 19, 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(Country)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Sophie Nowakovsky M.D.

M. D. or other

Address

Date signed

RECEIVED  
DEC 27 1945  
BUREAU V. &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-27

## CERTIFICATE OF DEATH

Reg. Diat. No. 12532 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

4844 Cordell Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4844 Cordell Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Rufus Jackson Rice

## 3.(b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widowed

## 6.(b) Name of husband or wife

Dora D. Rice

## 7. Birth date of deceased (mo., day, yr.)

November 30, 1956

## 6.(c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

8907

.....hrs. ....min.

## 9. Birthplace

Harris County, Georgia

(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

Mail Carrier

FATHER

## 12. Name

Edwin Monger Rice

## 13. Birthplace

N.C. Carolina

MOTHER

## 14. Maiden name

Rebecca Smith

## 15. Birthplace

Georgia

## 16. Informant

Mrs. Elsie Rice Ray

## Address

4844 Cordell Ave. Bethesda, Md.

## 17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof Dec. 9, 1945  
(month) (day) (year)

## Cemetery or crematory

Rosemary Ann

## Location

Alatama

## 18. Funeral director

W. W. Chambers

## Address

3072 M. St. N.W.

## 19.

Dec. 8, 1945

(Date rec'd by registrar)

Wm E Jones

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1945, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1947, to December 7 1945and that I last saw him alive on December 6 1945

Immediate cause of death

Intestinal Obstruction

## DURATION

1 week

Due to

Carcinoma of Large Bowel

Due to

Other conditions

Senility

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Brucet Benjamin M.D.

M. D. or other

Address Bethesda, Md. Date signed 12/27/45

RECEIVED

DEC 17 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

Bethesda Hospital6 hours 52 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington D.C.City or town National Cathedral School  
(If outside city or town limits, write RURAL and give nearest town)Street No. National Cathedral School  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Willie Roberts

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white single

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

April 20, 1897

8. AGE:

Years

Months

Days

If less than one day

48727hrs.min.

9. Birthplace

Charlottesville, Va.  
(Town, county, and state)

10. Usual occupation

Miller

11. Industry or business

FATHER

12. Name

John Roberts

13. Birthplace

Va.

MOTHER

14. Maiden name

Beulah Watson

15. Birthplace

Va.

16. Informant

Sirie StensonAddress National Cathedral School

17.

(Burial, cremation, or removal. Which?)

Date thereof

Dec 19, 1945  
(month) (day) (year)

Cemetery or crematory

Barboursville Church

Location

Barboursville

18. Funeral director

J. W. M. Lees Sons

Address

300-4th St NE Wash. D.C.

19.

(Date rec'd by registrar)

12/181945Wm E Jones  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17, 1945 at 8:47 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 17, 1945 to 12:00 noon 12/17 19

and that I last saw him/her alive on

12/17/45 19

Immediate cause of death

Acute Pulmonary Edema

Due to

Acute Heart failure

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Jagers M.D.

M. D. or other

Address

8016 Tenetown Rd.

Date signed

9/17/45  
Bethesda

RECEIVED

DEC 26 1945

BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

29 days + 5 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4936 Auburn Ave.  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

William Rullmann Jr.

## 3. (b) Social Security Number

578 07 82 724. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower6. (b) Name of husband or wife Ollie

7. Birth date of deceased (mo., day, yr.)

June 4, 1883.

8. AGE:

Years

Months

Days

If less than one day

62623

hrs.

min.

9. Birthplace

Annapolis, Md.  
(Town, county, and state)

10. Usual occupation

Book-keeper

11. Industry or business

MOTHER FATHER

12. Name

William Rullmann

13. Birthplace

Md.

14. Maiden name

Sarah Meckley

15. Birthplace

Penn.

16. Informant

Mrs. Norman Titus

Address

Bealeville - Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

12/30/45  
(month) (day) (year)

Cemetery or crematory

Location

Bealeville - Md

18. Funeral director

Mr. B. Helton

Address

Barnesville - Md

19.

12/28  
(Date rec'd by registrar)

19

45Mr. E. J. Lee  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1945 at 7:25 P.

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from

Sept - 2 - 1945 to Dec - 27 - 1945and that I last saw him alive on Dec - 26 - 1945

Immediate cause of death

DURATION

Splenic Leukemiaunknown

Due to

Due to

Other conditions

Severe pyelitis;  
Concussive infection  
(Include pregnancy within 3 months of death)1-2 weeks1-2 weeks

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE

William B. Miller M.D.

M. D. or other

Address

Guthrieburg, MdDate signed 12/28/45

REC

JAN 2 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12535

Reg. Dist. No. 216

1. PLACE OF DEATH:  
 County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Colo. County \_\_\_\_\_  
 City or town Denver  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2120 Glenarm Pl.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME  
RUMMELHART, Vincent John, AMM2c USN

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Helene Rummelhart  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) 16 Oct. 1923  
 8. AGE: Years 22 Months 1 Days 19 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Iowa (Town, county, and state)  
 10. Usual occupation Navy  
 11. Industry or business \_\_\_\_\_  
 12. Name John C. Rummelhart  
 13. Birthplace Iowa  
 14. Maiden name Dorothy M. Sanders  
 15. Birthplace Ill.

10. Informant wife: Mrs. Helene Rummelhart  
 Address 219 Cleveland Avenue, Riverside, N.J.  
 17. removal Date thereof 12-5-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Olivet Cemetery  
 Location Riverside, Iowa  
 18. Funeral director Geo. W. Wise J. C. J.  
 Address 2900 M St., N. W., Wash., D.C.  
 19. 12-5 45 Mary Charlotte Smith  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1945 at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep Med Exam case 1945 to 1945 and that I last saw him alive on 1945

Immediate cause of death Intra Cranial Hemorrhage  
Branchial pneumonia  
 Due to pulmonary occlusion

## DURATION

12 days

4 days

Due to Struck by automobile  
 Other conditions fracture of 1st clavicle  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of 12-23-45  
 Where did injury occur? Hypothetical Brain Yes Med  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) Highway  
 Means of injury Struck by auto Injured at work? No  
Frank J. Bronhart M.D.  
 23. SIGNATURE Dep Med Exam M. D. or other \_\_\_\_\_  
Yarrington med Date signed 12-5-45  
 Address \_\_\_\_\_

RECEIVED

DEC 17 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Diat. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 29 hours

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? 29 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Pr. Geo.City or town Brentwood  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3702 Utah Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

RUSSELL, Maude Elizabeth

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

W-US

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 18 July 1879

6. (c) If alive, give age years

8. AGE: Years 66 Months 4 Days 22 If less than one day  
hrs. min.9. Birthplace Ark.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name FATHER Herman Walker13. Birthplace Va. (dec)14. Maiden name MOTHER ? Burns15. Birthplace Tenn. (dec.)16. Informant son: Lt. Comdr. James L. RussellAddress 2702 Utah Avenue, Brentwood, Md.17. burial Date thereof 12-12-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Ft. LincolnLocation Washington, D. C.18. Funeral director Francis GASCH'SAddress 4739 Baltimore Avenue, Hyattsville, Md.19. 12-10-45 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Dec. 19 45, at 7:50 am21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Dec. 19 45, to 10 Dec. 19 45and that I last saw him er alive on 10 Dec. 19 45Immediate cause of death Coronary thrombosis DURATION 48 hrs  
with Myocardial InfarctionDue to Generalized Arterio Sclerosis 2 yearsDue to Arterio Sclerosis Heart  
S. disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results Coronary thrombosis - Infarction Date of op. 12-12-45  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

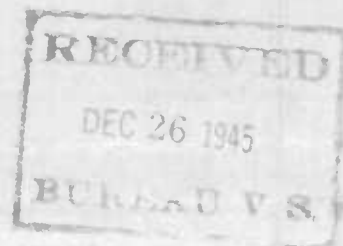
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gordon R. Lamb M. D. or otherAddress US Naval Hospital, Bethesda, Md. Date signed 12-10-45



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 96

## CERTIFICATE OF DEATH

12537

Reg. Diat. No. 223-

### 1. PLACE OF DEATH

County Montgomery County

City or town Beltsville Park Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sept. 3, 1945

Hospital, institution, or street address where death occurred:

45 - Poplar Ave

How long in hospital or institution? 3 months 2 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery County

City or town Beltsville Park  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 45 - Poplar Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war No

### 3. (a) FULL NAME

Henry W Sandmeyer

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Anna Malida

7. Birth date of deceased (mo., day, yr.) March 7, 1858 6.(c) If alive, give age 20 years

8. AGE: Years 87 Months 8 Days 28 If less than one day — hrs. — min.

9. Birthplace Thay Ill.  
(Town, county, and state)

10. Usual occupation Retired Government Employee

11. Industry or business Government

12. Name Jacob Tom Sandmeyer

13. Birthplace Germany

14. Maiden name Ernestine Louise Neier

15. Birthplace Germany

16. Informant Helvin W Sandmeyer

Address 5134 - Nebraska Ave NW

17. Burial Date thereof Dec 9, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Washington D.C.

18. Funeral director The B. H. Jones Co.

Address 2901-14th St NW

19. 12/5 19 45  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 19 45, at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 45, to Dec 5 19 45 and that I last saw him alive on Dec 4 19 45

Immediate cause of death Coronary dilatation

#### DURATION

Sudden

Due to

Due to

Other conditions all age general debility

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

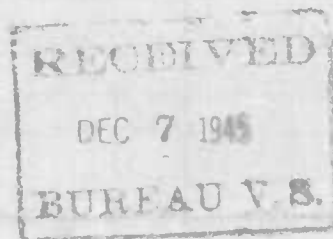
23. SIGNATURE W. M. A. Shannon M.D. M. D. or other

Address 113 Carroll St. W. Md. Date signed 12-5-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 109

## CERTIFICATE OF DEATH

12538

Reg. Dist. No. 218

1. PLACE OF DEATH: Montg Co,  
 County.....  
 City or town..... Germantown (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Md..... County..... Montg.....  
 City or town..... Germantown, P. D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME Effie Bell Schafer

3. (b) Social Security Number

4. Sex..... Female..... 5. Color or race..... White..... 6. (a) Single, married, widowed, or divorced..... Married.....  
 6. (b) Name of husband or wife..... George A Schafer..... 69.....  
 7. Birth date of deceased (mo., day, yr.)..... June 3rd 1870..... 6. (c) If alive, give age..... years.....  
 8. AGE: Years..... 1870..... Months..... 75..... Days..... 5..... It less than one day..... 19..... hrs..... min.....  
 9. Birthplace..... Frederick Co, Md.,  
 (Town, county, and state)  
 10. Usual occupation..... House Wife.....  
 11. Industry or business.....  
 12. Name..... Solomon Fritz.....  
 13. Birthplace..... Md.....  
 14. Maiden name..... Sarah Slimmer.....  
 15. Birthplace..... Md.....

16. Informant..... George A Schafer.....  
 Address..... Germantown Md.....  
 17. Burial..... 12/24/45.....  
 (Burial, cremation, or removal. Which?)..... Date thereof..... (month) (day) (year)  
 Cemetery or crematory..... Locus Grove Cemetery.....  
 Location..... Locus Grove, Near Libertytown, Md.....  
 18. Funeral director..... Ernest C Gartner.....  
 Address..... Gaithersburg Md.,.....

19. Dec 23 1945.....  
 (Date rec'd by registrar)..... Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Dec 22..... 1945..... at 5:30 am..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 Dec-21-1945 to Dec-22-1945  
 and that I last saw him alive on Dec-21-1945

Immediate cause of death.....  
 Subar pneumonia.....  
 DUE TO.....  
 DUE TO.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

DURATION

5 days

Major findings of operations.....  
 Date of op. ....

An autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town)..... (County)..... (State).....  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....

23. SIGNATURE..... William C. Miller, M.D.  
 Address..... Gaithersburg, Md.  
 Date signed..... 12/22/45

RECEIVED

DEC 27 1945

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12539 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda, (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 hours  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 10 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D. C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3233 Ellicott St., N. W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_ ✓

### 3.(a) FULL NAME

SCHUETTE, Patrick William, Midshipman USMS

### 3.(b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife \_\_\_\_\_ 6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Jan 8, 1928

8. AGE: Years 17 Months 11 Day 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Highland Park, Ill  
(Town, county, and state)

10. Usual occupation midshipman

11. Industry or business \_\_\_\_\_

12. Name Mr. Oswald Schuette

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant fa: Oswald Schuette

Address 3233 Ellicott St., N. W., Wash., D.C.

17. burial Date thereof 12-31-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Washington, D.C.

18. Funeral director Hines Funeral Home

Address 2900 14th St., N. W. Wash. D.C.

19. 12-28 45 Mary Charlotte Smith  
(Date rec'd by registrar) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Dec. 1945 at 11:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Dec. 1945 to 28 Dec. 1945

and that I last saw him Sept 2nd same case 1945

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Int. cranial hemorrhage 13 hrs

Due to \_\_\_\_\_

Auto accident 12-28-45

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. 12-29-45

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-28-45

Where did injury occur? Cherry Chase Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury auto accident Injured at work? no

23. SIGNATURE Frank J. Brochart M.D.

Dep. Md. State M. D. or other \_\_\_\_\_

Address Washington Md Date signed 12-29-45

MARGIN RESERVED FOR BINDING

VS A16 42515M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1/8/46

RECEIVED

JAN 10 1946

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

Reg. Dist. No. 212

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Sellman (outside)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Sellman (outside)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles V. Sewell

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

col

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

Dec 17 1945

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

10

hrs.

min.

## 9. Birthplace

Sellman, Monty Co., Md  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

FATHER

## 12. Name

Percy Jackson

## 13. Birthplace

Md

MOTHER

## 14. Maiden name

Christa Sewell

## 15. Birthplace

Md

## 16. Informant

Percy Jackson

## Address

Sellman, Md

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

12 27 45  
(month) (day) (year)

## Cemetery or crematory

Mt. Zion

## Location

Sellman, Md. R.F.D.

## 18. Funeral director

Wm. B. Hilton

## Address

Barnesville, Md.

## 19.

(Date rec'd by registrar)

Dec 27 19 45Mrs. C. C. Hilton  
by Mrs. Hilton

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec 27 1945 at H. A. A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1945 to Dec 1945  
and that I last saw h. Examin Case alive on 19

Immediate cause of death

DURATION

Pneumonia3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury

Injured at work?

23. SIGNATURE

Frank J. Broschack M.D.  
Dys. Med. Exam

M. D. or other

Address Yantherburg, Md Date signed 12 27 45

RECEIVED

JAN 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1600

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 hrs - 22 min

Hospital, institution, or street address where death occurred:

Washington Sanitarium + Hosp. TolHow long in hospital or institution? 16 hrs - 22 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 711 Guilford Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Renee Frances  
unnamed baby girl Smith

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

## 6.(b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

12-13-45

## 6.(c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

16 hrs. 22 min.

## 9. Birthplace

Takoma Park, Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Carl Rossman Smith

## 13. Birthplace

Camden, N.J.

## 14. Maiden name

Gloria Georgia Mc Caffrey

## 15. Birthplace

Pittsburg, Pa.

## 16. Informant

Sanitarium Records

## Address

## 17.

(Burial, cremation, or removal, which)

## Date thereof

12-14-45  
(month) (day) (year)

## Cemetery or crematory

George Washington Mem Cemetery

## Location

11th St. & Scatterhill, Maryland

## 18. Funeral director

J. Arthur Dooling

## Address

254 Carroll Dr. N. W. Park Park D.C.

## 19.

Dec 14 1945  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14 1945, at 5:16 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-13- 1945, to 12-14- 1945and that I last saw her alive on 12-13-45 1945

## Immediate cause of death

Atelectasis lungs

## Due to

knot in umbilical cord

## Due to

which interfered with  
circulation in brain  
respiratory centers.

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

## 23. SIGNATURE

Emma Hughes M.D.  
M. D. or otherAddress Takoma Park, Md. Date signed 12-14-45

RECEIVED

DEC 19 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4674

## CERTIFICATE OF DEATH

Reg. Dist. No. 12542

## 1. PLACE OF DEATH:

County MONTGOMERY  
 City or town TAKOMA PARK, D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 YRS.  
 Hospital, institution, or street address where death occurred:  
5 MONTGOMERY AVE.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County MONTGOMERY  
 City or town TAKOMA PARK  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5 MONTGOMERY  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

BASCOM ANDERSON STUBBS.

## 3. (b) Social Security Number

534-03-8014

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

EVELYN T. STUBBS

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

SEPT. 18, 1904.

8. AGE:

Years

41

Months

2

Days

26

If less than one day

hrs. min.

9. Birthplace

S. CAR.

(Town, county, and state)

10. Usual occupation

TYPEWRITER MECHANIC

11. Industry or business

FATHER

12. Name

W.M. LANDRY STUBBS

13. Birthplace

S. CAR.

MOTHER

14. Maiden name

NANCY M. ANDERSON

15. Birthplace

S. CAR.

16. Informant

MRS. EVELYN T. STUBBS

Address

5 MONTGOMERY AVE

17.

(Burial, cremation, or removal. Which?)

BURIAL

Date thereof

DEC. 17, 1945  
(month) (day) (year)

Cemetery or crematory

ST. DAVID'S CEMETERY

Location

CHERAW, S. CAR.

18. Funeral director

J. ARTHUR WALTERS

Address

254 CARROLL ST., N.W., TAKOMA PARK, D.C.

19.

(Date rec'd by registrar)

Dec 14 1945

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 14, 1945 at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10/311945

to

12/141945and that I last saw him alive on 12/14 1945Immediate cause of death retinal hemorrhage

DURATION

minutes

Due to

Cerebral hemorrhage of the brain

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Bleeding of brain and throat cancer

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. O. Leonardo

M. D. or other

Address

5801-13th St NW

Date signed

12/14/45

RECEIVED

DEC 15 1945

BUREAU V. H.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Montgomery  
Village or City Cherry Chase (No. 4015 - Oliver St.; Ward)

2 FULL NAME Nellie E. Sweet

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 216

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH June 22 1867  
(Month) (Day) (Year)

7 AGE 78 yrs. 6 mos. 6 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Idaho

PARENTS  
10 NAME OF FATHER John Sweet  
11 BIRTHPLACE OF FATHER (State or country) Idaho  
12 MAIDEN NAME OF MOTHER Nancy Wells  
13 BIRTHPLACE OF MOTHER (State or country) Michigan

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs. Geo. Vase  
(Address) 4015 - Oliver St.

15 Filed 12/29, 1945 Mr. E. Jones  
REGISTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 28, 1945  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1945 to Dec. 28, 1945, that I last saw her alive on Dec. 24, 1945 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH \* was as follows:  
Coronary thrombosis

Contributory Arterio sclerosis  
Secondary

(Signed) G. C. Birdsell M. O.  
12-28, 1945 (Address) 1832 - Kal. Rd. Wash

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death yrs. mos. ds. In the State, mos. ds.  
Where was disease contracted, If not at place of death? X  
Former or usual residence X

19 PLACE OF BURIAL OR REMOVAL Cedar Hill Cem DATE OF BURIAL 1945

20 UNDERTAKER Mr. R. Humphrey ADDRESS Beth Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Senate and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Marine engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired) etc.*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

JAN 3 1946

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Remover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23a

## CERTIFICATE OF DEATH

12544

★ Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

8408 Greenwood Ave

How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8408 Greenwood Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Robert Daniel Tanslynn

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) April 30 1945

8. AGE: Years Months Days It less than one day

717hrs.min.9. Birthplace District of Col.  
(Town/county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Wm E. Tanslynn13. Birthplace Willsboro Pa14. Maiden name Martha Hettrick15. Birthplace Cleawille Pa16. Informant Wm E. TanslynnAddress 8408 Greenwood Ave. Takoma Park Md17. Burial Date thereof Dec 18th 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Altoona, Penna18. Funeral director W W Chambers Co.Address Riverdale Md.19. Dec. 17 45 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945, at 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Ref med Exam 19 to 19

and that I last saw h..... alive on ..... P. 19.....

Immediate cause of death.....

DURATION

.....

Broncho-pneumoniaDue to Influenza

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury Injured at work?

Frank J. Brouhaert M.D.23. SIGNATURE Ref med Exam M. D. or otherAddress Frederick Md Date signed 12-17-45

RECEIVED  
DEC 19 1945  
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12545 218

## 1. PLACE OF DEATH

County... Montgomery  
 City or town... Rural Gaithersburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
Beth Shalom Home  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md. County... montg.  
 City or town... Gaithersburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Maudie Walters

## 3. (b) Social Security Number

4. Sex F 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife... Ambrey H. Walters  
 6.(c) If alive, give age... 32 years

7. Birth date of deceased (mo., day, yr.) May 2 1912

8. AGE: Years 33 Months 7 Days 10 If less than one day  
 ..... hrs. .... min.

9. Birthplace... Madison County, Va.  
 (Town, county, and state)

10. Usual occupation... Housekeeper

11. Industry or business... own home

12. Name... John Griffin

13. Birthplace... Va.

14. Maiden name... Pearl Gradier

15. Birthplace... Va.

16. Informant... Ambrey H. Walters

Address... Gaithersburg Md.

17. Buried Date thereof... 12/16/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or place of interment... Walden Chapel Cemetery

Location... Madison Co. Va.

18. Funeral director... Ernest B. Galtner

Address... Gaithersburg Md.

19. Dec 14 19 45 Maudie S. Cooke  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Dec 12 19 45, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 11 19 45, to Dec 12 19 45

and that I last saw him/her alive on Dec 12 19 45

Immediate cause of death... Coronary Embolism

DURATION

Due to.....

Due to.....

Due to.....

Due to.....

Other conditions... Confinement case

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE... M. D. or other

Address... Gaithersburg Md. Date signed... Dec 12 1945

RECEIVED

DEC 18 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age **MARYLAND STATE DEPARTMENT OF HEALTH**  
 & birth date of deceased is shown on 2411 N. Charles St., Baltimore (77)

12546

216

FILM No. I 00 JAN 8 1946

# CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Montg.  
 City or town Bethesda Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution or street address where death occurred:  
Suburban Hosp  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town 112 W. Montg. Ave  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rockville, Maryland  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Kate R. Warfield.

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 8. (b) Name of husband or wife David H.  
 7. Birth date of deceased (mo., day, yr.) March 16, 1878 1868  
 8. AGE: Years 65 Months 9 Days 0 If less than one day  
 77 65 hrs. min.

9. Birthplace Rockville, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business

12. Name Mathew Fields  
 13. Birthplace Virginia  
 14. Maiden name Rebecca Beckwith  
 15. Birthplace Rockville Maryland

16. Informant Miss Rebecca Fields  
 Address 112 W. Montg. Ave  
 17. Bureau Date thereof 12/19/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Marys Cemetery  
 Location Rockville, Md.

18. Funeral director Wm Reuben Humphrey  
 Address Bethesda Md.  
 19. 12/19 1945 Wm E Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1945 at 5 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
10 Dec 1945 to 16 Dec 1945  
 and that I last saw him alive on 16 Dec 1945

Immediate cause of death Acute Hemorrhage  
 Due to Ruptured Vessel  
 Due to Arteriosclerosis  
 Other conditions

DURATION  
6 days  
6 day  
20 years

(Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE W. S. Murphy M.D.  
Rockville, Md M. D. or other  
 Address Date signed 17 Dec 45

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED

DEC 26 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12547 218

## 1. PLACE OF DEATH:

County MontgomeryCity or town Woodlith  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William J Warfield

## 3. (b) Social Security Number

20

4. Sex

Male

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

William Griffith Warfield

7. Birth date of

deceased (mo., day, yr.)

Dec 26 18666. (c) If alive, give age 70 years

8. AGE:

Years

78

Months

11

Days

24

If less than one day

hrs. min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

Farm

FATHER

12. Name

John J Warfield

13. Birthplace

Maryland

MOTHER

14. Maiden name

Rachel Darry Griffith

15. Birthplace

Rachel Darry Maryland

16. Informant

William Griffith Warfield

Address

Laithersburg Md

17. Burial

Dec 23 1945

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Green Md

Location

Montgomery Co Md

18. Funeral director

Rose W Barber

Address

Stonewille Md

19. Date rec'd by registrar

12/23/45

19. (Date rec'd by registrar)

45L D Bell

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Woodfield

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1945 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 13 1945, to Dec 20 1945and that I last saw him alive on Dec 18 1945Immediate cause of death Cerebral Hemorrhagewith Paralysis

DURATION

9 daysDue to Atherosclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accidental, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE Vernon H Dyson M D

M. D. or other

Address Laymanville Md Date signed Dec 23/45

RECEIVED

RECEIVED

RECEIVED

DEC 29 1945

REAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

## CERTIFICATE OF DEATH

Reg. Diat. No. 219

## 1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

7 1/2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Derwood  
(If outside city or town limits, write RURAL and give nearest town)Street No. R. 7 D. #1 Nr. Redland  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Julia Waters.

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married.

6. (b) Name of husband or wife

Mr. Worthington Waters

B. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

June 16, 1875

8. AGE:

Years

Months

Days

If less than one day

70612

hrs.

min.

9. Birthplace

Redland, Maryland  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home.

MOTHER FATHER

12. Name

Henry B. Magruder

13. Birthplace

Derwood, Maryland.

14. Maiden name

Laura Beatty

15. Birthplace

Williamsport, Maryland.

16. Informant

Hospital records

Address

17.

Removal  
(Burial, cremation, or removal. Which?)

Date thereof

Dec 28 1945  
(month) (day) (year)

Cemetery or crematory

Bethesda Md

Location

18. Funeral director

Wm. R. Humphrey

Address

Bethesda Md

19.

12-28-  
(Date rec'd by registrar)

19.45

Gertrude B. Lawler

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1945 at 1:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1942 to Dec. 28 1945and that I last saw her alive on December 28 1945

Immediate cause of death

Acute myocarditis

DURATION

1/2 hr.

Due to

Chronic valvular heart

Due to

degenera4 yr.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. J. Boush M. J.

M. D. or other

Address Gaithersburg, MdDate signed 12/28/45

RECEIVED

JAN 7 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8012-24014

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12549246

1. PLACE OF DEATH: Montgomery  
County Bethesda - Md  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
River Road  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME  
James Beverly Weedon

3. (b) Social Security Number

4. Sex M 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct 1869

8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Spottsylvania Va.  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business same

12. Name Beverly J. Weedon

13. Birthplace Va.

14. Maiden name Rose Gray

15. Birthplace Va.

16. Informant Mrs. Inez Cole

Address 6037 - River Rd. Md.

17. Removal Date thereof 12/8/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Washington D.C.

18. Funeral director Thomas H. Hrazian Co.

Address 389 - R. I. Ave. N.W.

19. 12/7 19 45 7m E Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7th 1945 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 18, 1945 to Dec. 7th 1945 and that I last saw him alive on December 6th 1945.

Immediate cause of death Chronic myocardial insufficiency } 3 years  
Due to age

Other conditions Pulmonary congestion } ten days  
(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Wheeler O. Huff

Bethesda, Md. Date signed Dec 7-45

RECEIVED  
DEC 17 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

## CERTIFICATE OF DEATH

12550

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (Rural) Norbeck  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Bethesda (Rural) Norbeck  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Richard H. White

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male col Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 31 1884

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: 61 Years Months 11 Days If less than one day

1945 Jan 2 hrs. min.

9. Birthplace Montgomery Co. Maryland  
(Town, county, and state)10. Usual occupation labourer

11. Industry or business

12. Name John White13. Birthplace unknown14. Maiden name Annie White15. Birthplace Maryland

16. Informant

Address

17. Burial Date thereof December 6, 1945  
(Burial, cremation, or removal, Which) (month) (day) (year)Cemetery or crematory Mt Pleasant CemLocation Norbeck, Md.18. Funeral director R. L. Sniderman

Address

Rockville Md.19. Dec - 4 1945  
(Date rec'd by registrar)

Gertrude B. Law  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1945 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. med. Exam case 1945 to 1945  
 and that I last saw him alive on 1945

Immediate cause of death

Acute Cardiac  
dilatation

DURATION

1/2 hr.

Due to

Acute Nephritis24 hrs.

Due to

Other conditions

(Include pregnancy within 6 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Frank J. Bronchart M.D.  
Sup. Med. Exam M. D. or other

Address Washington Md. Date signed 12-3-45

RECEIVED

JAN 2 1946

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12552

★ Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County MontgomeryCity or town Clarksburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Clarksburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_ no

## 3. (a) FULL NAME

Benjamin F. Wims

## 3. (b) Social Security Number

No

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Harriet Ann Wims6. (c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) June 27, 18678. AGE: Years 78 Months 6 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Montgomery County, Md.

(Town, county, and state)

10. Usual occupation Laborer11. Industry or business Farm12. Name Sam Wims13. Birthplace Mont. Co., Maryland14. Maiden name Rachael Posey15. Birthplace Mont. Co., Md.16. Informant Harriet Ann WimsAddress Clarksburg, Maryland17. Burial Date thereof January 1, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory John WesleyLocation Rockey Hill, Md.18. Funeral director Roy W. BarberAddress Laytonsville, Md.19. Dec 31 19 45 Abundant G. Corde

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-29- 1945 at 4 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Nov-6- 1945 to Dec-29- 1945and that I last saw him alive on Dec-28- 1945

Immediate cause of death \_\_\_\_\_

## DURATION

Cardio-vascular 7 weeks

Due to \_\_\_\_\_

Due to Senility 5 yrs

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William O. Miller M.D.Address Clarksburg, Md.Date signed 12/31/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE CITY OF NEW YORK

CONTAGIOUS DISEASES

RECEIVED  
JAN 3 1946  
BUREAU V.B.

2

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BD*

12551

## CERTIFICATE OF DEATH

Reg. Dist. No. *2/3*

## 1. PLACE OF DEATH

County *Montgomery*City or town *Rockville*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *5 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD* County *Montgomery*City or town *Rockville*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *Beck Lane*  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

*Branson Wims*

## 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *widowed*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *March 3, 1889* 6. (c) If alive, give age *56* years8. AGE: Years *56* Months Days If less than one day hrs. min.9. Birthplace *Maryland*  
(Town, county, and state)10. Usual occupation *Cook*

11. Industry or business

12. Name *Benjamin F. Wims*13. Birthplace *Maryland*14. Maiden name *Elizabeth Hudson*15. Birthplace *Maryland*

16. Informant

Address

17. *Burial* Date thereof *Dec 8, 45*  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory *Rocky Hill Cem.*Location *Clarksburg, Md.*18. Funeral director *B. L. Snodden*Address *Rockville, Md.*19. *12/8/45* *Josephine D. Walton*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec 4* 19*45*, at *130 a* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec 1* 19*45*, to *Dec 4* 19*45*and that I last saw *him* alive on *Dec 4* 19*45*Immediate cause of death *Chronic myocarditis*

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *C E Hawks* M. D. or otherAddress *Rockville Md* Date signed *12/6/45*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 11 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

Reg. Dist. No. 12553 714

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rural - Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Glenmont-Colesville Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rural - Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. Glenmont-Colesville Rd.  
(If rural, give LOCATION)2.(a) If veteran, name war X

## 3.(a) FULL NAME

Yvonne Rosalie Wolfe

## 3.(b) Social Security Number

-X

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>female</u>	<u>white</u>	<u>single</u>

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 1st. 1942

8. AGE:	Years	Months	Days	If less than one day
<u>3</u>	<u>8</u>	<u>10</u>	..... hrs.	..... min.

9. Birthplace Upperville, Va.  
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Hobart H. Wolfe13. Birthplace Edenburg, Va.14. Maiden name Nora Ellen Miller15. Birthplace Edenburg, Va.16. Informant Hobart H. WolfeAddress Rt. 1 Silver Spring, Md.17. Burial Date thereof 12-13-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ColesvilleLocation Colesville, Montg. Co. Md.18. Funeral director Werner E. PumphreyAddress Silver Spring, Md.19. Dec 12 1945 Josephine M. Schaeffer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1945 at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sympt med Exam case  
and that I saw h..... alive on ..... 19.....

Immediate cause of death

Pneumo-pneumonia  
Due to

Due to

Other conditions Richards  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

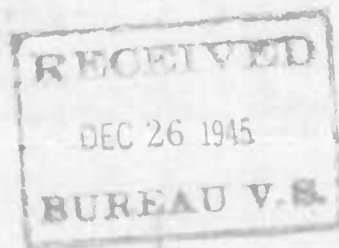
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Bruchant M.D.  
Sympt med Exam M. D. or otherAddress Glenmont-Colesville Rd Date signed 12-11-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 12554 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 daysHospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.How long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5707 32nd St., N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

YOUNG, Kenneth James, Flc V-6 USNR

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

W-US

## 6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 11-4-25 6.(c) If alive, give age years8. AGE: Years Months Days If less than one day  
20 1 10 .....hrs. ....min.9. Birthplace Washington, D. C.  
(Town, county, and state)10. Usual occupation Navy

11. Industry or business

12. Name Russell B. Young13. Birthplace Pa.14. Maiden name Pearl E. Butz15. Birthplace Pa.16. Informant Father: Mr. Russell B. YoungAddress 4707 32nd St., N.W., Wash., D.C.17. burial Date thereof 12-18-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director Geo. W. Wise Co J.C.F.Address 2900 M St. N.W., Wash., D.C.19. 12-15 45 Mary Charlotte Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Dec. 45 at 10:49P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Dec. 45 to 14 Dec. 45  
and that I last saw him alive on 14 Dec. 45Immediate cause of death acute encephalitis DURATION 2 wksDue to Neurotropic virus

Due to

Other conditions Terminal pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Acute encephalitis - pneumonia  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Officer Injured at work?23. SIGNATURE B. F. ECKHARDT, Lt. Comdr. (MC) USNRAddress USNH Bethesda, Md. M. D. or other 12-15-45  
Date signed

RECEIVED  
DEC 27 1945  
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (984)

## CERTIFICATE OF DEATH

Reg. Dist. No. 213-

## 1. PLACE OF DEATH:

County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 YEARS

Hospital, institution, or street address where death occurred:

Woodlawn Sanatorium -How long in hospital or institution? since October 3, 1943

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Itanwood  
(If outside city or town limits, write RURAL and give nearest town)Street No. 118 Woodlawn Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mary Benjamin Zetelle. (Born, Wallace)

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

widowed -6. (b) Name of husband or wife Antonio Zetelle

B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan. 27 1859.

## 8. AGE:

Years

86

Months

10

Days

25

If less than one day

..... hrs. .... min.

9. Birthplace Pottsville, Pennsylvania

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business own home12. Name Francis Wallace13. Birthplace New York City14. Maiden name Frances Wallace15. Birthplace England16. Informant Mr. Gladys J. WinterAddress 110 Woodlawn Ave. Kenwood, Md.17. Wash. D. C. Date thereof 12-21-45

(Burial, cremation, or removal (Which?)) (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director Joseph Paulsen SonsAddress 1756 Pa. Ave Wash. D. C.19. 12/21/45 - Josephine D. Shallen

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 1945 at 12:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 1943 to December 30 1945and that I last saw him alive on December 20 1945Immediate cause of death Hypostatic pneumonia

DURATION

2 DAYSDue to Congestive Heart FailureDue to myocardial degenerationOther conditions Senility

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Vietha Zetelle L.C. M. D. or otherAddress Rockville, Md Date signed 12/31/45

RECEIVED

DEC 26 1945

BUREAU U.S.